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HEALTH CARE FOR THE UNINSURED

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JUNE 19, 1989 (WASHINGTON, DC)
JUNE 28, 1989 (SOUTHFIELD, MI)

(Part 1 of 2)

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CONTENTS

MONDAY, JUNE 19, 1989

OPENING STATEMENTS

Page

Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan, chairman of the subcommittee 1
Mitchell, Hon. George J., a U.S. Senator from Maine 4
Durenberger, Hon. David, a U.S. Senator from Minnesota 5
Rockefeller, Hon. John D. IV, a U.S. Senator from West Virginia 7

COMMITTEE PRESS RELEASE

Finance Subcommittee on Health To Hold Hearing on the Uninsured 1

CONGRESSIONAL WITNESS

Kennedy, Hon. Edward M., a U.S. Senator from Massachusetts 8

PUBLIC WITNESSES

Lewin, Lawrence S., president, Lewin/ICF, Washington, DC 19
Ray, Hon. Robert D., co-chairman, National Leadership Commission on Health Care, DeMoines, IA 27
Rogers, Hon. Paul G., co-chairman, National Leadership Commission on Health Care, Washington, DC 29
Fein, Rashi, Ph.D., professor, economics of medicine, Harvard University School of Medicine, testifying on behalf of the Committee for National Health Insurance, Washington, DC 31
Schramm, Carl J., Ph.D., J.D., president, Health Insurance Association of America, Washington, DC 37
Babcock, C. Patrick, director, Michigan Department of Social Services, and co-chairman, Governor's Task Force on Access to Health Care, Lansing, MI 50
Post, Bonnie D., chairperson, Maine Special Select Commission on Access to Health Care, and executive director, Maine Ambulatory Care Coalition, Augusta, MA 52

WEDNESDAY, JUNE 28, 1989

OPENING STATEMENT

Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan, chairman of the subcommittee 59

COMMITTEE PRESS RELEASE

Finance Subcommittee on Health To Hold Hearing on the Uninsured 59

PUBLIC WITNESSES

Dilloway, Arlene and David, Imlay City, MI 64
Eichler, Cheryl, Woodhaven, MI 69
Renaud, Carole, Warren, MI 72
Benfer, David W., executive vice president, Henry Ford Hospital, Detroit, MI 76
Boucree, Michael, medical director, Hamilton Family Health Center, Flint, MI 81

Page
McCammon, David N., vice president, finance, and treasurer, Ford Motor Co., accompanied by Jack Shelton, manager, Employee Insurance Department 87
Erwin, J.W., owner, Erwin Farms, Novi, MI 89
Hoffman, William S., director, Social Security Department, United Auto Workers, Detroit, MI 92
Serafini, Martha, administrator, Good Neighbor Fund, Bronson Hospital, Kalamazoo, MI 96
McDonald, Beverley, executive director, Michigan League for Human Services 99
Lane, Linda, director of the Flint, Michigan, Health Care Pilot Program for the Michigan League for Human Services 103

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

Babcock, C. Patrick:
  Testimony 50
  Prepared statement 107
Benfer, David W.:
  Testimony 76
  Prepared statement 119
Boucree, Michael:
  Testimony 81
  Prepared statement 124
Chafee, Hon. John H.:
  Prepared statement 127
Dilloway, Arlene and David:
  Testimony 64
  Prepared statement 128
Durenberger, Hon. David:
  Opening statement 5
Eichler, Cheryl:
  Testimony 69
  Prepared statement 130
Erwin, J.W.:
  Testimony 89
  Prepared statement 131
Fein, Rashi:
  Testimony 31
  Prepared statement 132
Hoffman, William S.:
  Testimony 92
  Prepared statement 135
Kennedy, Hon. Edward M.:
  Testimony 8
  Prepared statement with exhibits 139
Lane, Linda:
  Testimony 103
Lewin, Lawrence S.:
  Testimony 19
  Prepared statement 179
McCammon, David N.:
  Testimony 87
  Prepared statement 181
McDonald, Beverley:
  Testimony 99
  Prepared statement with attachment 182
Mitchell, Hon. George J.:
  Opening statement 4
Post, Bonnie D.:
  Testimony 52
  Prepared statement 211
Ray, Hon. Robert D.:
  Testimony 27
  Prepared statement 215

Page
Renaud, Carole:
  Testimony 72
  Prepared statement 218
Riegle, Hon. Donald W., Jr.:
  Opening statement 1, 59
  Prepared statement 220
Rockefeller, Hon. John D. IV:
  Opening statement 7
Rogers, Hon. Paul G.:
  Testimony 29
  Prepared statement 215
Schramm, Carl J.:
  Testimony 37
  Prepared statement 224
Serafini, Martha:
  Testimony 96
  Prepared statement with enclosures 227

COMMUNICATIONS

American Medical Association 233
American Academy of Actuaries 241
American Public Welfare Association 246
Manufacturers' Alliance for Productivity and Innovation 248
Older Women's League 253
U.S. Chamber of Commerce 256
Responses to a request for comments by Senator Riegle 258

HEALTH CARE FOR THE UNINSURED

MONDAY, JUNE 19, 1989

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senators Mitchell, Rockefeller, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-36, June 9, 1989]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON THE UNINSURED

WASHINGTON, DC—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Subcommittee on Health for Families and the Uninsured, announced Friday the Subcommittee will hold a hearing on proposals to provide universal access to health care.

The hearing is scheduled for 10 a.m. on Monday, June 19, 1989 in room SD-215 of the Dirksen Senate Office Building.

"I've called this hearing to focus on developing a solution that will provide universal access to health insurance for all Americans. This hearing will explore the strengths and weaknesses of a variety of proposals," Senator Riegle said.

"A growing number of Americans have limited access to health care services. Today, we have about 37 million persons in this country with no health insurance; tragically, 12 million of these are children, the most vulnerable of our society," Riegle said.

"High quality, affordable health care should be available for all Americans and their families. One of my priorities is to see that all Americans have access to health care when they need it," said Riegle.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The Committee will come to order. Let me encourage those in the room, to the extent they can, to try to find seats or places to stand. We welcome everybody today. I think the size of the audience indicates the keen interest that there is on this very important national subject.

Let me welcome all of you and we have some very distinguished witnesses today, leading off with our colleague, Senator Kennedy. I am going to make a brief opening statement and then ask other Committee members for opening comments they have and then we will be very pleased to hear from Senator Kennedy.

Today, we are tackling one of the most pressing problems confronting our nation. It is an astonishing fact that 37 million Americans have no health insurance coverage at all. And tragically, 12 million are children—our young people, who are in many ways the most vulnerable in our society. So today, we are exploring a variety of proposals for providing universal access to health insurance for every American citizen of all ages.

My colleague, Senator Mitchell, former Chairman of the Subcommittee on Health, held hearings last year examining this problem. This year, Senator Mitchell and I are continuing the work begun last year to develop legislation that can provide comprehensive, affordable health care coverage for every person in our country.

We have learned that the uninsured expand all ages, employment statuses and income levels. Many of the people are falling through cracks in our employment-based system of health care. Two-thirds of the people who have no health insurance are employed individuals or the dependents of employed individuals. So this destroys the myth of the notion that only those who are out of work are the ones that lack health insurance. It is quite the contrary.

The program for low-income people is also inadequate and over one-third of our uninsured persons are below the Federal poverty level. It is important to note that close to 40 percent are in what we actually call middle or so-called upper income groupings. So again, it raises questions as to why the health insurance coverage is missing. When we look closer, we find it is because many people, after they have met the other basic necessities of shelter, food and transportation to and from work and so forth, are just unable to afford the very high cost of health insurance, particularly if it is not available through some kind of a group insurance plan.

Many workers and families do not qualify because they work part-time, are between jobs or work in industries such as retail or service sectors that do not provide health coverage at all. In many instances, the employer does not cover the dependents of the employee. They will cover the worker but not the spouse or the children. It is particularly alarming that almost 30 percent of uninsured children live in households where the family head, in fact, has coverage themselves through their workplace but it just does not extend on to other members of the family.

Our nation's public program, Medicaid, finances services for only certain categories of low-income persons, primarily single women with children. For example, a single man or woman, no matter how poor or sick, simply would not qualify for Medicaid. If fact, Medicaid only covers 40 percent of the poor in our country.

Individuals without health insurance are less likely to obtain care. One million Americans annually are denied health care because they cannot pay for it. An additional 14 million do not even seek care that they feel they need because they know they do not have the money to pay for it or any insurance coverage.

Shifting costs of uncompensated care to private payers drives up the cost of private health insurance. In the highly competitive health care marketplace, a hospital's ability to cost shift lessens and their capacity to provide care to the medically indigent is greatly eroded. Ultimately, the financial distress of hospitals that provide large amounts of uncompensated care threatens the quality and the availability of this care and, in fact, is having the effect of threatening the shut down of hospitals, particularly in areas where they are the most needed.

I am very concerned that while the United States has the highest per capita health care spending rates, our system of private and public programs leaves huge gaps in coverage that indicate a radical maldistribution of resources.

I first introduced a Bill on the uninsured in 1982 and have introduced Bills on this topic during the last four Congresses. We began that effort by focusing on unemployed persons who had lost their health insurance and we have since broadened that out to more comprehensive legislation to deal with the full range of the problem.

In Michigan, we have 1 million uninsured individuals, with over 300,000 who are uninsured children. Michigan has a larger proportion of uninsured, unemployed adults and uninsured persons below the poverty level as compared to the United States as a whole. You will hear testimony from the Governor's Task Force of Michigan on activities and recommendations from my State on how to solve these problems.

I think it is significant to say that now American business is coming forward because those companies that provide comprehensive health insurance are finding that their rates are going through the ceilings because they are having to carry the load of the costs that are accruing for the uninsured and for the uncompensated care. And so, even those employers who are the most responsible in providing health insurance are finding that they are being asked to carry a second burden that in effect represents the shortfall of others in the society that provide no health insurance at all or very limited health insurance.

This problem has to be solved. If the United States is going to close the trade deficit, if we are going to lift ourselves up to the level of national productivity and output that we need, then everybody in the society has to be able to produce. And in order for people to be able to produce, they have to be educated and they have to be healthy. If we have people in this country that have health problems that cannot be met, then there is no way that the United States is going to be able to meet its responsibility to achieve the level of national performance that we just have to have, now and in the future, to compete in the global marketplace.

So, we have to view every person in our society as a critical part of the team—of team America. And so those individuals who are out there, who have health needs that are unmet, those needs have to be met. Children that need medical inoculations or treatment when sicknesses arise, or their parents or whoever it happens to be in the society, they all need to be well, healthy functioning Americans. There is just no excuse to have it any other way. We cannot afford not to have the health insurance in place and the time has come to get the job done.

I think we can do it. I think we can do it in this session of Congress if everybody works together. We asked the Administration to testify this morning and they declined to testify. I am disappointed that that is the case. But I know they share some of these concerns. I know they have started to work on this, but I would hope that before long they would have something very specific to be able to present. We will be happy to schedule another hearing at any time when they are ready to come in and put forward a proposal that they think can help move us ahead.

Now I want to yield to my colleagues and then I want to introduce Senator Kennedy who has been such an important leader on the issue of national health care for many years. So, with that, let me yield to Senator Mitchell.

[The prepared statement of Senator Riegle appears in the appendix.]

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, I thank you and commend you for holding this hearing today to focus on the problem of access to affordable health care for all Americans.

There are 37 million people in this country without any health insurance—public or private. Twelve million of the uninsured are children. Almost two-thirds are poor. Many are people with pre-existing medical conditions, who despite their income, cannot purchase health insurance. Access to affordable, high-quality health care for all Americans must be one of our primary goals as a nation. Meeting that objective will be difficult. It will require the participation of both the public and private sectors.

Our health system is mixed, including employer-sponsored health insurance for workers and their dependents and Medicaid coverage for the poor. Unfortunately, this mixed system fails to provide millions of Americans with access to basic health care. Private employer-sponsored insurance is leaving more and more employees, and their dependents, without insurance. Medicaid is covering a smaller proportion of the poor.

Two-thirds of the persons are employed persons or their dependents. Many of them do not have the opportunity to purchase health insurance plans where they work because their employers do not offer them. Still others, at the lowest end of the salary scale, cannot afford to purchase insurance plans, even when they are available. We must act to help the many young families, struggling to make ends meet, who do not have and cannot buy health insurance.

This Committee has made a considerable effort in recent years to improve access to care for the elderly. We have also worked diligently to increase Medicaid coverage for poor mothers and their children. Unfortunately, Medicaid still covers only half of poor children. Any comprehensive plan to provide access to health care for our citizens must include further expansions of basic benefits for poor mothers and their children.

We are pleased to have the Chairman of the Senate Labor and Human Resources Committee, Senator Kennedy, with us today. Senator Kennedy has devoted more time and effort to resolving this problem of uninsured than any other member of Congress and he is to be commended for it.

We are also fortunate to have the benefit of the experience of a number of State initiatives to address access to affordable health care. Today, we will hear testimony from the Michigan Governor's

Task Force on access and from the Maine Special Commission on Access to Health Care.

In Maine, approximately 130,000 of our population of just over a million are uninsured or underinsured. The Maine Commission on access to health care, comprised of a number of concerned organizations and citizens worked together for more than a year to put together a proposal to provide access to care for a significant part of this population. That Commission will be represented here today by its Chairperson, Bonnie Post, a former State Legislator, and now Executive Director of the Maine Ambulatory Care Coalition, a good friend and an outstanding advocate for good health care for all Americans.

I believe that Maine's experience, and that of other States, can give us at the Federal level a better understanding of some of the possible solutions to this problem on a national scale. The State's experience in dealing with various political interests may also be helpful as we continue to work to bring together diverse interests toward our common goal of providing affordable, high quality health care for all Americans.

Mr. Chairman, I regret that I will be unable to stay for the entire hearing.

Senator RIEGLE. Let me just indicate, too, before you leave how important your leadership has been in this area over a period of time. I think we are now at a point where maybe we can put it all together. I very much view the work of this Subcommittee as a continuation of the structure—building the structure—that you have helped put into place. We are very appreciative of that.

Senator MITCHELL. Thank you, Mr. Chairman.

Senator RIEGLE. Senator Durenberger.

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you very much. Let me express my appreciation to both of you for the thoroughness of your statements and my anticipation of the first witness today who represents, more than any of us, I guess, a national commitment to provide financial access to every American into the health insurance system.

I have a little button I got. Senator Kennedy and I are both on the Bi-Partisan Commission, the Pepper Commission, it makes it a Bi-Partisan Commission. When we had our first hearing of that Commission we were in Minnesota and somebody gave me this button that says, "Insure the Uninsured." While that is a solution to the provide, and I suspect today we are going to spend some time on both defining the problem and the solution, I think Senator Kennedy represents for all Americans a person who spent all of his time in the United States trying to make this a reality.

If I may be allowed an observation, it is that the definition on the button changes from time to time. I make the argument, Mr. Chairman, that we have always had national health insurance in this country and it is called doctors, and hospitals, and nurses, and folks like that who will take care of you even if you cannot afford to pay them. That has been the American national system. If you have an ache or a pain or a doubt or a question, you can walk in the door and somebody will take care of you and they will make up the cost of your care by charging it to somebody else or by defraying their own economic expectations.

But because of the work we have done in this Committee over the last few years on prospectively pricing Medicare and a lot of other things, that is no longer possible. I think one thing we have decided in this country, we are going to pay more explicitly for the services that we need to deliver. So now our task becomes more difficult because not only do we have to define the problem, we have to be very, very specific about the solution.

There are various ways to ensure financial access into this system. But the first is to define what it is that we mean by insurance. I think all I would like to do in my statement is make the point that we cannot get agreement in this room very readily about insured access to health care in this country because in many cases we have destroyed our understanding of insurance. I think the big debate we had two weeks ago on catastrophic was illustrative of the fact that a lot of Americans do not any longer understand what it means to pay for something you do not get just to have the assurance that it will never happen to you; but if it did happen to you, you would be taken care of. Maybe only 10 percent of folks benefit, but that is the nature of the problem.

In America, we have the opportunity, if we define insurance as financial protection, to define that in terms of earnings, savings, private insurance, social insurance and income maintenance in one way for those who are not eligible currently for our social insurance program. That is for people who have to buy their way into the system.

We have a lot of things in America that we, in effect, can have for nothing. You do not pay explicitly for your police and fire protection. That just kind of happens. You do not pay explicitly for your public schools, that is just sort of there for you. You do not pay explicitly in many jurisdictions for a lot of your other related utility. You do not pay if you are a communication worker working for AT&T, you do not pay for your health care either.

Which gets me to the point of one of the things that is wrong with America. It is not that we are the richest nation on earth and to be compared with South Africa repeatedly. It is the fact that all of the riches are on one side of the scale and all of the inability to get into the system are on the other side. It is not due to public policies put in place on purpose. It is due to our failure to deal with the inequities that have been created over the last 30, 40 years in that system.

I looked at the AT&T contract and I cannot believe it. I cannot believe that in America today we are still giving away, with a tax subsidy behind it, more free health care access than most of those people need and we are charging it to the taxpayers. I sat down and I figured out that the tax subsidy that underlies that AT&T contract is bigger than what you would need if you wanted to buy child health insurance protection, like Lloyd Bentsen recommends, you know, you could buy more protection if you just took that subsidy for a kid with just the tax part of that subsidy.

I mean, the reality is that in America a big number of people have a lot more health insurance protection by far with tax subsidies than they need, while 37 million Americans do not have access to the system. And that, I think, Mr. Chairman, is your struggle on this Subcommittee. It is the struggle we went through last year on catastrophic when we tried to redesign one part of the social insurance system. It is obviously a struggle that Senator Kennedy and others have gone through as they define the best way to access all Americans to health insurance in this country.

Senator RIEGLE. Thank you very much, Senator Durenberger. Let us just note, too, that you, as a member of this Committee, have just joined and become a member of the Labor and Human Resources Committee, of course, of which Senator Kennedy is Chairman. So I would say with the Majority Leader now in his position, his great interest in this subject, and the people that we have in the right spots on the right Committees, if we cannot get this done now, something is radically wrong with the system itself. I think we can get it done.

Let me just now call on Senator Rockefeller, who has recently been elected the Chairman of the Bi-Partisan Commission on Comprehensive Health Care, replacing Claude Pepper. That is an enormous responsibility, but it is on the right shoulders.

Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I will just simply be very brief. I would say to our lead-off witness, Senator Kennedy, that he does not need any education in terms of our situation in West Virginia. But we do have 30,000 more uninsured in West Virginia than we did in 1980; 16 percent of all West Virginians are without any health insurance whatsoever; there are 54,000 West Virginians who are uninsured, even though at least one of their parents is working; only 37 percent of West Virginians with incomes below the poverty level are in fact getting any benefits under Medicaid—which is an extraordinary statement to have to make.

It seems to me that a baby needs well-baby care; a pregnant woman needs prenatal care; a child needs his or her shots. They are not getting them. And both, through the Pepper Commission and through this Subcommittee, we have to do something about it. We have to do something about it, oddly, at a time when there is neither the money to do something about yet and yet neither the moral opportunity not to do something about it.

Senator RIEGLE. Thank you very much, Senator Rockefeller.

Senator Kennedy, everyone has acknowledged your leadership over the years in terms of trying to bring health care and health insurance to citizens of our country. Certainly in your own life time and in your own family and personal circumstances, you have seen the incredible things that can happen that can require care and medical attention of various sorts. I do not know that there is anyone who might better be able to address this subject for us than yourself. We welcome you and we are very pleased to have you today.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman. I, too, want to join in commending you, not only for having this hearing, but for your strong commitment in ensuring that in this Congress that we really are going to make a downpayment in setting an inevitable course that is going to assure good quality health care to all Americans as a matter of right. I just want to indicate right at the top that we are, in the Labor and Human Resources Committee more than willing, we are eager, we are enthusiastic of working with you Mr. Chairman, the other members of this Committee, in working closely to achieve that objective.

As you have rightfully pointed out, with the mix of our different Committees and also with the challenge to the Pepper Commission of which Senator Rockefeller is the Chairman, we do have an extraordinary opportunity. I believe very deeply that to be able to do this we have to have a strong bi-partisan ethic. That is the way that we have been able to make progress in the most important areas of human need in the past; that is the way that we are going to have to do that in this particular issue. I believe that the interest is there, the commitment is there, and we are looking forward to working both with you and other members of the Senate.

We were fortunate in the last Congress to pass out of our Committee the legislation which I will describe here today. We are committed to assuring that will be passed out of our Committee sometime. I am hopeful, certainly, in the July markup. We are looking forward to working with you in every step along the way.

Mr. Chairman, this health issue is back on the American agenda. We have had the report of the bi-partisan Presidential Commission—President Ford and President Carter. We have had the Ford Foundation that has given its report, the New England Journal of Medicine has identified the need for addressing these issues. We have a Commission which has been established in the Congress, made up of members of the House and Senate.

So we really do have a unique opportunity and I think as you pointed out, we will fail our responsibility unless we take advantage of it.

What I would like to do, I would like to file my statement in its entirety in the record.

Senator RIEGLE. We will make it a part of the record.

[The prepared statement of Senator Kennedy appears in the appendix.]

Senator KENNEDY. I know that the attention spans, both of our colleagues and all are of such a nature that we want to—at least I would like to present very briefly the nature of the problem that has been recognized by the members here; very briefly how we intend to address it; very briefly what I consider to be the principal concerns of the members of this Committee—focused on children, small business and the disabled; and then very briefly give what I consider to be the alternatives; and then a very short summation.

It seems to me that that is the way that we can probably best proceed. I would hope that as a result, if we examine the various proposals within that context, I am very hopeful that the conclusion of those who are fashioning the policy will agree with our conclusion. As the Chair and others have pointed out, this first chart shows the increasing numbers of those who are uninsured. There is an expectation, even though it has flattened out in the past few years, that the number of uninsured will begin to move up for various reasons which I can elaborate on later in the testimony but are really not necessary to make the point.

This second chart indicates that 60 million Americans either have insurance which is inadequate to meet the catastrophic expenditures which are defined as $3,000 out-of-pocket. So we have 2.4 million Americans who have out-of-pocket expenses of more than $3 thousand every single year and you have the 60 million who are vulnerable to catastrophic health expenses.

The next set of information comes from the Robert Wood Foundation. One million Americans are denied every year care because they cannot afford to pay it. We have tried to address this problem in our Committee. We found that that number has been somewhat reduced but it is still there. We have jurisdiction with the old Hill-Burton legislation. But as we have seen a reduction in charity care and budgets of hospitals being squeezed, this is increasingly a problem.

We have 14 million people who do not seek care because they cannot pay, are denied, or do not seek care—this totals 15 million Americans. That is another feature of the health care crisis. Increasing numbers are not covered; increasing numbers are not receiving the care, with all the implications that that has with complicating health issues. Of the 37 million, 22 million are employed, some 14 million are not employed.

How then do we address these issues? We have a mandate—I call this the decency requirement that requires all employers to provide the health insurance, meeting the minimum standards to all workers and dependents—not a Cadillac plan, a little Ford Pinto plan. We phase it in. The Federal/State public program provides coverage for the remaining uninsured. We will outline how that can be phased in. That can be adjusted more rapidly or less rapidly in terms of the budgetary considerations. But you can move towards the mandate in a very quick way and really come to grips with the overwhelming majority of the number of uninsured.

There is no real mystery about the basic package of health benefits employers would be required to provide to their full-time employees. It is actuarial. It is about what 95 percent of the businesses are providing today. We have an equivalency program so that if there is some kind of an adjustment or change in terms of what is required here and what a business is providing, if it is actuarially equivalent, then it is sufficient in terms of meeting the requirements. But these are the basic benefits: physician, hospital services, diagnostic, prenatal, well-baby care. It does provide the $3,000 out-of-pocket limit and coverage for deductibles and co-pays for low-wage workers. When you go from the poverty rate to 185 percent you increase the employee contribution to 20 percent—$250 deductible per individual; $500 per family; out-of-pocket limits of $3,000—and that is the end of it for a family per year.

The bottom two items I draw to your attention. These are really spelled out in charts that have hopefully been made available to you. We have a regional insurer program providing community rated insurance coverage for currently uninsured and small businesses. Small business today is treated enormously inequitably in the terms of trying to provide any kind of coverage.

You have 60 percent of employers, with 25 employees or fewer, do provide it. A quarter of those who are uninsured are actually in business with 1,000 or more employees. So it is more a problem for the small businesses, but still there are many of the larger companies and corporations that are not providing health insurance coverage. Small businesses are paying anywhere from 20 to 30 to 40 percent more in terms of premium cost. If you a small businessman and you have 10 or 15 employees and you have one serious illness or sickness by one individual, your premiums jump or the whole company loses. They are enormously at risk and we have to try and deal with it. They are treated differently in the tax law.

So those issues have to be addressed. What we have tried to do is to permit, one, the consortium of insurance companies with sufficient interest to be able to bid on various contracts that are going to lower the overall purchasing cost for the small business. Then what we have done is written in a small business subsidy for those businesses for whom the cost of compliance would be excessive. That figure is 5 percent above the gross revenues. We took that basically from the Hawaiian plan.

Let me just mention at the beginning, this kind of program is in effect today in the United States, in the State of Hawaii. The healthiest State in the nation—Hawaii. Some can say, well, it is Hawaii. They could make a pretty good case for that. But nonetheless, they have had this program in effect now for some 20 years, strongly supported by the business and working community.

Now, we phase this in; we do the mandated program—it would come in 2 years after the passage of the legislation. Then we phase in the public problem, the 12 million who are not being covered. The first phase covers all uninsured poor Americans. That would be phased in by 1991. Then the second phase is by 1996. That covers those insured between 100 and 185 percent of the poverty level. The final phase covers all the remaining uninsured persons after that. This program can be varied and adjusted in terms of the financial conditions which all of us are very familiar with.

This is just another chart that indicates pretty much the same features. It just gives you the percentages of those who are not covered over the period of the three phasing ins. This is an elaboration of the insurance market collapsing system. Businesses with 25 or fewer employees, pay 20 percent more than larger businesses; 10 or fewer employees, 35 percent; pre-existing conditions and other exclusions deny coverage for illness that poses the greatest risk.

If you have someone with a pre-existing condition, that small business is out. And if they get sick during the year, the greater the chances that they will lose or they will find their premiums are increasing at a dramatic rate. We can go into further detail on it, but let me keep moving along.

This proposal guarantees coverage for the smaller businesses. Exclusions on the basis of pre-existing conditions are prohibited. The regional insurer program provides community rating guarantees of fair average price, regardless of health status. Regional insurers would insure economies of scale and would reduce administrative costs further through managed care systems. The total price reduction we believe in terms of premium is about 25 percent.

We allow new small businesses, to purchase low-cost coverage during their start-up period. They are phased in and are only required to provide low-cost coverage during the first 2 years.

Now let us get back to points that have been raised by the different members of this body in their opening statements, and that is the children. With the coverage of this program, in the first phase we reach 82 percent of all the uninsured children in America—82 percent are reached, with the pre-natal and well-baby care for all pregnant women and infants, including 600,000 uninsured deliveries and coverage of the 16,000 uninsured high cost.

So for those that—I have heard it in testifying here. I know Senator Chafee, Senator Packwood, others—yourself and others—have talked about the children having been left out. This program really moves us in a very significant way in covering the children who are not covered today. And I think in any program, that ought to be a priority item. This particular item does reach 82 percent of the children that are not covered.

On the disabled, the main feature that affects the disabled is eliminating the exclusion on the basis of pre-existing conditions. It guarantees the coverage for the 3.2 million who are uninsured disabled adults and the 426,000 disabled. Let me raise this point, Mr. Chairman, you have 7 million disabled Americans today who are covered and a very substantial percent of those fear moving their jobs because they are going to lose any coverage. They are basically imprisoned, in many respects, in that employment situation.

So for the children we phase that in at the first phase. For the disabled—for the 7 million who now are covered, but would lose their coverage if they moved to another—we basically provide the protection for those. Plus, we reach out for the disabled children, the uninsured and those with pre-existing conditions. In terms of the disability movement, this is the heart of their kind of a protection. So this program in terms of the children and the disabled, these issues will be addressed in a very important and significant way.

Now, what are the alternatives? We tried to outline briefly what the problem is—not only in the numbers, but who we're getting it. We tried to show at least how we address it in terms of the mandate; how the second part, the public aspect, can be phased in, and how we are targeting both the children and the disabled and the steps that we have taken. We would welcome—because this is the Committee that has the experience in terms of working on that particular feature—but we have attempted to be sensitive to the particular concerns of the small business.

That is our program.

Now the alternative solutions—the European/Canadian national health insurance. We could expand the Medicaid program, or we have the basic health benefits program. Those are basically, I believe, the three different choices that we are facing.

On the European/Canadian national program there are theoretical advantages. I have been a supporter of it in the past. It does provide the basic human right to health care. But quite frankly, given where we are today—it would take a radical shift in terms of the thinking of this population. I am someone who has been in this business for a time. It will take a radical change in the relationship between the providers and the payees. This program would mean more central control and it would shift the payment burden. It will take a lengthy process to build that consensus and I do not believe that we can ask the 37 million Americans to wait.

So there is that way of approaching it and I think it presents complications.

This is important, and if it can have your attention particularly. Let's look at the numbers if we were to just expand the Medicaid requirement for employers. We now have 5.9 million uninsured nonworkers and 10 million uninsured nonworkers, plus uninsured workers. We have poor who are not working, so we add those to the list. You have poor who are working and have some coverage because you have about 5 million of them that are covered with insurance. And then you have poor who are working with no coverage. Those are the three categories.

So if you say, well, we will just expand the Medicaid program, you are going to take those who are not covered. I cannot believe that a businessman who is going to know that if you are going to have a Medicaid program to provide coverage for an expanded poor population, he is going to have to say, why am I going to have to take that as a business cost. So that is going to add 5 million more. And then if we do not have a mandated program, you are going to have 5 million more who are working for businesses that but who are not covered.

So instead of it moving from a pool of 5 million, you begin to move from covering individuals not only under poverty but 150 percent of poverty which equals up to 24 million. You get up to 14.5 million just with those three categories I have talked about. So any concept of just adjusting the Medicaid program is going to, number one, be enormously expensive and costly. It is going to disinsure even those that have some insurance today. It is going to switch into the public those that could be covered by a mandated program.

So if we now say that the European model is out because of the reasons I have outlined, if you talk about the expanded Medicaid, I think you are going down an open road towards extraordinary commitments in terms of public policy and, basically, I think it would undermine the private employer-based system.

Senator Durenberger. Ed, could I interrupt with a question at that point?

Senator Kennedy. Sure.

Senator Durenberger. I agree with everything that is on that chart. But I tend to think of Medicaid now not as the welfare system into which you put everybody—and you are absolutely right, I mean, if we continue to run it like the welfare system and you are going to change the qualifications all the employers are going to dump their little dollar employees in there.

But, if you think about it as a part of the social insurance system that will make contributions to premiums in much the way Lloyd Bentsen would like to make $1.4 billion a year in contributions to certain premiums subsidies—not exactly that way, but a similar way—where the employer goes out and buys the health insurance the Medicaid system, depending on the income of the employee, makes a contribution, then is it not worthwhile looking for some of the employees at least—and this takes nothing away from your overall plan, it is just a different way to look at Medicaid as it relates as a payor to this system— wouldn't that overcome some of those objections?

Senator KENNEDY. I would dare say that examining that concept in detail, I think you are going to find that it is really not going to meet the objectives. Let me just give you a partial answer, which is the bottom part of this. Seventy-five (75%) percent of uninsured workers and dependents are not poor; and 61 percent are not near poor. So you are not reaching those individuals. I think you have to run out the figures on that to find out both the cost and to whom you are providing the incentives and the disincentives. It would be my observation—and I hear what you are saying and we have looked into that in terms of the public policy—I really think you are going to, by the time you hook into those kinds of incentives and the rest, you are talking about an Administration and a bureaucracy. We would be glad to work with you, Senator, to try and see whether, there is some kind of transition.

We have not been able to see it. But I hear what you are saying and let me give you a complete answer on it.

Senator DURENBERGER. Thank you.

Senator KENNEDY. I would just say, finally then, that the Basic Health Benefits Plan builds on our current system. It represents a burden shared by the employers and taxpayers. It has balance. We do have co-pays, we do have deductibles. We do ensure that those who are in poverty are going to be able to get coverage and then the ability to pay in terms of their participation. Hopefully, with implemented, over a period of time, it would address the particular gaps that exist in the current system.

So that is it very briefly. I have outlined it in greater detail in the rest of the statement. This is a program which is not greatly dissimilar to the program that was advanced by President Nixon and introduced by Senator Packwood on this Committee. It has some variations and changes. By and large, most of the essential aspects of this problem, I think, have been evaluated by some very significant groups and panels who have some of the most thoughtful and knowledgeable people in the whole health policy area.

We would like to discuss information on the questions of the costs. We have had CBO submit what the overall costs would be, what the net cost would be. We are basically talking about, for this kind of coverage, about $.55 an hour per employee—that much of addition on the increase in minimum wage—$4.00 a day. About a 3 percent increase in the total expenditures for health care. As we phase in the first part of the public program, costs come to about $5 billion and then move on through. The rest of the phases are now being reviewed.

The latter phases are going to be less because you are going to find individuals who have a greater ability to share cost. We have two econometric studies done on this program. Whether it adds additional inflationary impact in terms of the economics. This is about one-tenth of one percent. We would like to submit information with regards to what the impact will be on employment—both employment in the health industry and the general kind of employment figures which we have reviewed and which we are glad to submit.

[The information appears in the appendix.]

Senator KENNEDY. Again, I am very grateful to you for your willingness to hear this. I apologize for rolling through this presentation in this way. But I think if we are able to catch the concepts, we are more than glad to sit down with you or the members of your staffs to flesh out greater details of some of the various provisions.

But I thought it was important, at least, to get the conceptual approach for why we believe that this offers the best opportunity to address the need of the uninsured given all the factors in this Congress.

Senator RIEGLE. Well, thank you. That is a very helpful presentation. I appreciate the level of detail that we have been able to get into here.

I would like to make just three points. One is a suggestion. And that is, I think it would be important for us to create a small working group at the professional staff level that would include staff representatives of Senator Durenberger, Rockefeller, Mitchell, myself, and yourself, and others, to keep it fully bi-partisan, to enable us to take some differences in thinking and to mesh those into a working plan.

I really think it can be done obviously the national imperative is there, but I see a way mechanically for us to take and put this together if we just work at it steadily.

I take it from your earlier comments, too, I know you favor a mandate for all employees to provide health insurance, but that your mind is open to the issue of using the Tax Code, through incentives or disincentives, as another way or perhaps a parallel way to really motivate employers to provide the health insurance to their employees. In other words, I take it that you are open to that as a part of this answer, if that looks like it would be a necessary way to go here.

Senator KENNEDY. The answer would be yes, Mr. Chairman. I call these minimum standards of decency, not mandated programs.

Let me say that I think it is absolutely essential with regard to the small business. I think it is absolutely essential. They are not treated even currently the way—in terms of how owner-operated businesses are treated. This individual is treated differently than somebody in his employ and there is a whole series of different elements there that can be very, very important. I think they are going to have to have some assurance that those very considerable, additional needs that they have are going to be addressed.

Senator RIEGLE. Well, it is important to hear that and I think there is a very strong argument that I want to try to frame here before yielding to Senator Durenberger. That is, I think not only can the Tax Code help us get this job done, but I think there is a justifiable national gain and goal out there to be achieved to the extent that we use a part of the Tax Code to get this job done. It goes back to this question of why is it so essential that we do this.

You mentioned moral imperative or a standard of decency. It seems to me that over the years, so much of the argument has properly rested on the notion of what is decent and right. Do we want sick people out there or are people who need health care not getting it? Should a modern nation like ours see to it that there is some way for everybody to have those basic health needs met.

So I think the moral imperative argument or decency argument has always been there. I think there is a new argument on top of that. The moral imperative argument by itself should have been sufficient; it has not been.

I believe there is an additional argument that now comes into play. I think because we now have a national performance problem in terms of what our trade deficit illustrates our shortfalls in national performance economically are showing us. We have got to achieve a higher level of performance as a nation. And just like any team, whether it is a basketball team or anything else, the Congress or anything we want to talk about, you have to have every part of the team working appropriately if you are going to have the right kind of an overall performance.

It seems to me if we have a situation, as with a high school dropout rate—just to make the analogy—of 24 percent compared to other nations, like Japan, having a high school dropout rate of 2 percent, then there is no way over time that we can perform up to the level of national achievement that we have to have. If our people are not able to do that, either because they lack the educational capability, or in this case, if they are not healthy and have not had the health care they need along the way, and therefore, they are just unable to perform up to the maximum level that otherwise they could achieve, then the whole country falls short of the mark.

Any time you have anything like 37 million people out of 240 million people who are in that situation, needing health care and not getting it, there is no way the nation as a whole can raise itself up to the level of performance that we have just got to have as we go into the 1990's and the year 2000. So it is beyond the question of decency.

I think it is now absolutely in the national interest of this country that we make sure that everybody is in a position to perform and deliver for themselves and for the nation as a whole. We just cannot afford, as a nation, to have people who need health care and are not getting it; and who, therefore, are just not able to rise to the full measure of their own potential.

I think now we are pressed in a new way. We cannot afford not to have it. We cannot afford to have malfunctioning individuals. We cannot afford to have it in education; we cannot afford to have it health. That is another reason why I think the drug problem has got to go much higher on the national list of effort than we presently see.

But it seems to me that we now are at a point where I would hope every business executive in this country—large, small, man, woman, whoever it happens to be—would see the notion of the value of having a national work force and people coming along into that national work force who are able to perform at peak potential—at peak potential. In order to do that, they have to be well and healthy. If they are not, then the nation is going to fall short by that amount. If we do, we are just not going to make it in the kind of global situation that we have today.

I would hope that we could begin to get that point out there. This is not a question of wasting money. This is a question of an investment that is absolutely crucial to the future of this country. We are not going to be able to succeed. The well, the wealthy and the healthy are not going to be able to succeed in the long run if the rest of our society is lagging behind. There is just no way. I mean the whole society has to go forward together.

That is why the team America concept is something that we have to understand. We might have been able to get away with it two or three decades ago when other nations were recovering from having been ravished in World War II. That is not the world we live in today. So we have to get everybody up to speed. It is right. It is necessary and I think we can get it done.

Senator KENNEDY. Can I make just one very brief comment, as you talk about competitiveness? In terms of our companies that are competing internationally, about 96 percent of them have health insurance that would meet that particular standard. What they are finding, as you pointed out, they are already paying now. Their premiums go up 25 percent or so a year now because they are the ones that are picking up for the uninsured.

So just in the area of competitiveness, in that very narrow area, they are paying more. And, of course, what is happening, in terms of the workers in those, since the cost of doing business is going up, the workers in those plants, even though they may be increasing in terms of productivity, cannot ask for any increase for their wages because the premiums are going up in that company versus a company that is not providing it.

So international competitiveness, business competitiveness, worker interest in terms of increasing their productivity—Chairman, you put your finger right on it.

Senator RIEGLE. Senator Durenberger.

Senator DURENBERGER. A lot of American plans here. When you start putting committees together, I want to be sure you have—I think it is—Med-America represented because John Chafee, your ranking member in this Subcommittee has been working very, very hard on this issue. Bill Bradley and I have been working on kids on a different approach. We do not have a name, yet, for ours. I hope that when—there are—I mean, the good news is that everybody is interested in helping resolve the problem.

At breakfast this morning—I took my interns to breakfast—and one of them had the temerity to say, "How long do you think you would like to stay in the Senate?" That is always a tough question to answer. I said, well, as long as—this place is full of surprises—and as long as you can count on this place to be full of surprises and I like to do it. I find myself now delighting in this conversation sitting between a former Republican and a former Democrat. [Laughter.]

Talk about competitiveness with Teddy Kennedy. You know, how he is going to turn this whole system around and he is going to use the work place and so forth to accomplish it. I guess if I had a day like this every day I would stay in the Senate forever. [Laughter.]

It is very enjoyable. But the point that you make, Mr. Chairman, about the significance of this Committee—I was just sharing with my colleague here the fact that the first year I was on this Committee was also the first year I think that Senator Kennedy was permitted to come and testify in front of this Committee. I remember being here at that time. We have always, somehow or ever, had these little artificial barriers sometimes between Committees, which I sense that are now down.

It really—for one who sits on both of these Committees—makes a whale of a difference. But you talk about using the Tax Code and I would just make this one observation. The regressivity that is currently built into the system needs to be dealt with. You can talk all you want about being economically competitive. There is a lot of unused potential in this system and a lot of basic waste in the current system because the system is regressive.

We use a payroll tax that taxes people on dollar one for a social insurance system in this country. As I spoke earlier, we have a very regressive tax subsidy. The bigger the company is, the more money it makes. And particularly if it is a utility and can pass its costs on to somebody else, you can have the tasmahal of health insurance benefits while in the same community you cannot afford the basics that you are talking about.

To me, that is a very regressive system that Labor and Human Resources can do nothing about, except fill the gaps, like Senator Kennedy is proposing to do. Fill the gaps that are left on this Committee. We are the ones that are creating those gaps in the system by continuing to perpetuate both the basic tax policy underlying these things and the tax subsidy.

I would just say that what he has done, as I have observed it, is made the decision to continue the American approach to this system. We are unique because we use the work place. That is the good news and the bad news at the same time. We have tens of thousands of people making decisions for us in this system. In Canada, the provincial governments basically make the decisions and then the doctors get in there and fill up the hospitals and things like that. But in this country, we have all of these thousands of decision makers who are all differently situated.

But I think what our colleague has decided is that, that still in the end is the better way to go than to go with one of these nationalized systems where the government basically makes the decision. Then the question gets to be, how can you afford to do it and how do you set up the system so that those employers make good decisions.

I would argue that the burden here for doing that is jointly shared between Labor and Human Resources and this Committee.

Senator KENNEDY. Could I just address this because Senator Durenberger has made a good point. We could spend a good deal of time about the reimbursement system—that is not for primary care and it reimburses too much for C-sections and not for natural births, and those things are done on Tuesday and Wednesday mornings and not in the afternoons. We can go through all the different kinds of, problems.

With all of those kinds of problems, I would hope that we would not hold the 37 million Americans who are not insured hostage to that. I know that Senator Durenberger is not saying that. I wanted to make that clear.

I can stay as long as anybody wants and give you the problems with our health care system and where the other kinds of plans, in terms of a more structured system vis a vis, the Canadian system that does it at a lesser percent of GNP, probably 9.6; we are 10.4 percent of GNP—includes in there all of the programs plus long-term care. But that is not on the table.

As we move through here, I would just urge triggering the thinking about this opportunity and this policy. I think all of us have been around here long enough that we know there is a timeliness about these issues. A few years ago we did the codification of the Criminal Code—passed it twice in the United States Senate. The first time in 200 years. It is going to take 200 more years before we are going to do it again, because there comes a timeliness about it.

The health issues come and go, as one who has been involved in it. I think it is here now. I would just hope that we do not make perfection the enemy of what is very useful, very worthwhile and very good. I know that is not Senator Durenberger's point when he was raising this, but that issue will come on up and I hope it can be put in at least some proportion. But that you do do what is doable in terms of the savings of tax expenditures, if we can do them in a way that is more equitable.

Senator RIEGLE. Senator Rockefeller.

Senator ROCKEFELLER. No particular questions, Mr. Chairman. But just to say two things. One is that I think the Senator from Massachusetts ought to be congratulated for continuing his fight, while at the same time trying to make adjustments within the perimeter of his program to allow it to become more acceptable to more different groups. I think that is a very hard thing to do without one, giving up your principles, which you have not; and secondly, keeping your eye on the so-called vote count, that is the possibility of getting it passed. I think that you have done that. I think that is tremendously admirable.

The other point I guess I would make is that on the timing question, I really think you are right on that because they say now that Medicare by the year 2005 is going to be more expensive than social security—going to cost more than social security at the rate that it is going. There comes a point when the argument of cost crushes merit and nobody can stand up to that. That time will be on us before long. So that what we are going to do with respect to long-term care and the uninsured—sort of the major, major undone problems that are before us—I think we have to strike quickly.

We have come to the point now where we are passing sham budget after sham budget after sham budget. Very shortly it will all catch up. I agree with you. I think we have to act very, very quickly. I thank the Senator from Massachusetts for his long, long fight on behalf of these and other problems.

Senator RIEGLE. I just want to say, Senator Kennedy, that I think you probably helped to illuminate this earlier than almost anyone—and that is, there is no way to escape the cost of these unmet needs. Society pays one way or the other. If we fail to recognize the health needs of our people—and people are sicker—the loss of what they might otherwise do for the society is part of the cost, but there is also a much higher medical cost. When people finally come in, they are far sicker; they come in with circumstances that require far more cost.

So it is not as if the country can escape the cost. The dollar cost is there either way. In fact, the dollar cost is much higher if we fail to recognize the need and move early. If we move early, we can spend this much and give people good, productive, positive lives to be able to lead. If we are so short sighted we do not do that, we are going to end up paying far more down the line.

And, of course, in addition, there is the heartache and suffering that has to go on in this society when you have so many people in circumstances where they are in ill health and cannot get any kind of assistance of any real consequence. This is just unacceptable in any modern nation that claims to have a conscience.

So we thank you.

Senator KENNEDY. Just to point out, when we had the earlier program about 18 years ago—the National Health Program—the highest estimates were $100 billion—$100 billion. We spent $460 billion last year. We will spend $540 billion this year.

So the Senator is quite correct. I appreciate the attention. Let me just say that we would welcome the opportunity to work with you, and whatever group you have. I think it is very useful for us to gain the thinking of the members of the committee. We understand there are very important aspects which obviously are of exclusive committee jurisdiction. We have no interest in touching on those. But we are very interested in working very closely with you in trying to achieve something for the millions of our fellow citizens that need this kind of protection.

Senator RIEGLE. We feel exactly the same way and we look forward to that kind of working arrangement.

Senator KENNEDY. Thank you very much.

Senator RIEGLE. Thank you very much for your testimony today.

Let me now invite Mr. Lawrence Lewin, who is the President of Lewin/ICF, to the witness table. We are delighted to have you with us today. We have taken some considerable time at the outset, and properly so, and so we will try to move along through our remaining six witnesses today.

Mr. Lewin, you and I have known each other for many years, going back to much earlier days. We are delighted to have you and would like to hear from you now.

STATEMENT OF LAWRENCE S. LEWIN, PRESIDENT, LEWIN/ICF, WASHINGTON, DC

Mr. LEWIN. Thank you very much, Mr. Chairman. I would like to add my congratulations to you and the members of your Committee. It is a real pleasure and an honor to be here in the company of people who have been working so hard on this issue for so long. Not just Senator Kennedy, who has been a leader for many years, but also many of the witnesses who will be following. I believe you have put together a most impressive panel of witnesses.

Apropos of your comment about timing, I remember being at a conference some 12 years ago in Chicago on health insurance in Canada and having a member of the panel stand up and say, "I have now heard what the Canadians have done, and drawing on an analogy from civil rights, I have concluded that national health insurance is an idea whose time has passed." I think it is clear now that that was both a premature and incorrect judgment, and that we are indeed at a time now when we have considerable interest growing in this question.

What I would like to do very briefly, is to serve as somewhat of a technical witness and lay out some of the issues having to do with various options and a framework for considering them. I will begin with some basic premises, talk about some of the major choices, and then talk about the framework. I believe members have a copy of my testimony.

Senator RIEGLE. We do.

Mr. LEWIN. First of all, on the basic premises, it is clear that not all of the 32 million or 37 million, depending on which survey you look at, of Americans who are uninsured are without access to health care. It is unfortunate they are without insurance, but the health care system does have other ways of providing for them. On the other hand, many of those with insurance are uninsured or lack coverage for important benefits. So the estimate of 37 million uninsured in one sense understates and in another overstates the issue.

Many of the uninsured are the nation's most vulnerable—children, adolescents, pregnant women, homeless—for whom access to health care is among society's best investments. The most serious need is not, in my view, for catastrophic coverage but for improved access to ambulatory care. I make this statement based on a number of studies that we and others have done that have shown that the failure to provide timely and appropriate ambulatory care and chronic care management have resulted in unnecessary and avoidable admissions, higher costs, and serious problems in terms of people's health.

The need, really, is in the form of preventive services, primary ~~care,~~ and chronic care management, which many existing insurance programs do not provide. These services, though demonstrably cost effective, are often excluded from current insurance programs.

The fifth point is that the present employment-based plus safety net system is inherently flawed. Senator Kennedy made that point in several ways. What is worse is that it is not showing signs of getting better; it lacks self-correcting mechanisms, and is worsening. Many people who have had employment-based insurance are losing it, and the Medicaid program clearly is not keeping up with the growth of the poverty population.

The sixth point is that there is, indeed, a broad consensus that seems to be building in support of universal access to health care, including some notable new enlistees, particularly from the business community. This coalition, while currently tenuous, I believe can be broadened and strengthened. And we see evidence of that taking place every day.

Seventh, any solution that we develop must contribute to greater economic discipline in the system as well as financing equity among the various parties involved. As we work with States and localities in trying to improve access, it is clear that one of the major obstacles is the belief on the part of many in the business community and in State legislatures that the system does not have enough economic discipline to make them comfortable about adding new dollars. Therefore, we must be mindful in whatever system we develop to build in effective forms of economic discipline; or, if you like, cost containment.

The eighth point is that given Federal fiscal constraints, we are likely to be faced with the need for a phased approach. It may be appropriate if we cannot solve the whole access problem at once at least to take advantage of current opportunities and consider particularly vulnerable groups, perhaps beginning with children and pregnant women—something that I know Senator Bentsen and several of you on this Committee and others have been considering.

And finally, what we have learned from the various studies that we have done is that this is a very complex system with highly interrelated parts. I believe Senator Kennedy made the point that when you change one part of the system it changes others as well. This has been demonstrated by a number of the studies that we have done. Therefore, any effort has to be based on a very careful calculation that takes account of these complex interrelationships.

The overall choices we face, it seems to me, are five. First, who should be covered. There no longer appears to be much argument but that everyone in America should have an opportunity to have access to health care. Perhaps not all by insurance and indeed for some Americans, an insurance card alone is not necessarily the best ticket to appropriate health care. Some of our calculations show that the marginal costs of providing universal access of some form to all Americans could be as low as $15 to $25 billion.

The benefits that should be covered are, of course, a major political question. I have made the point that ambulatory services are critical. But the critical issue here is do we have the discipline to develop a basic package or a "package for decency," as Senator Kennedy called it, that would enable us to avoid the kind of Christmas treeing that often becomes the case when we develop a minimum package.

I see the red is on.

Senator DURENBERGER. Mr. Chairman, could we permit this witness to extend his remarks for a few more minutes?

Senator RIEGLE. By all means. Sure.

Mr. LEWIN. Thank you, Mr. Chairman.

The public/private mix is an important question. I share Senator Kennedy's view that the British system, where the government owns the means of production as well as financing, and the Canadian system, where the government owns the whole financing system is probably not within our reach. There are other European approaches that assure universal access but rely more on a mix of private and public insurance. It seems to me that that is where we are headed, and the options I think deal with what the proper mix there is.

Another critical issue has to do with financing burden and how it should be distributed. There is considerable inequity in the current arrangement. Employers who offer insurance bear the double burden of paying for insurance as well as the health care cost of those whose employers do not provide insurance. There are free-riders in the system—employers, individuals, as well as providers; and there is the added question of who is actually paying the hidden taxes and subsidies that the current system imposes.

Now what I have shown on the next page really is modalities of access to care. I use these four basic modalities as an outline for the options—private insurance, public insurance, publicly-financed services, and a private voluntary system—I want to say just a word about the last two. The first two are well known; we talk about them all the time.

A significant portion of the care provided, particularly to the uninsured and low income members of our society are provided by publicly-financed services, where appropriations often go directly from State and local, and to some extent Federal, agencies directly to provide those services. That is a part of the system that is often overlooked in these discussions but is very important. It is large; it is often underfunded.

The fourth—and one that I think the President often refers to as the 1000 points of light—is the private voluntary system, which shares a major burden of the care for those who are uninsured. Probably $6 billion of the cost of providing hospital care is provided without compensation primarily by not-for-profit hospitals. We know that physicians provide charity care; we do not know how much. And we know that private agencies receive philanthropy.

Let me skip ahead to some of the ways of thinking about expanded access design options. What I have done here on these last two pages, Senators, is to list a variety of the kinds of options that are being considered right now. I will not go through all of them. You may find the list familiar; you may find it useful. What I want to do is to highlight some of the points that perhaps have not already been made or that need some emphasis.

First of all, under private insurance, we know that there are two basic kinds of private insurance. There is that provided in group settings, usually by employers; and that in nongroup settings. You may wish to refer to the page that precedes this, that shows some numbers on it. You might find reference to those numbers helpful.

In terms of expanding employer-based group insurance, there are really three approaches. First there is the mandated form in the Kennedy-Waxman bill, a kind of "thou shalt" provide insurance. The second is an indifference tax which the National Leadership Commission on Health Care in the Massachusetts Bill provides for, which essentially tries to establish a tax at a high enough level, so that an employer would be indifferent as between purchasing insurance or paying the tax. My own sense is that setting the tax equal to the current premium cost is too high, making it a very costly burden for many employers and that the real economic indifference level is lower.

So we have suggested considering something we might call a "contribution tax," which is really somewhat below the cost of insurance but one which helps to subsidize and finance the program.

Obviously, the more you collected in employer-based payroll taxes the less government needs to collect in general revenue—income—taxes. But the notion is that, if many employers are providing health insurance now, without a tax that creates an incentive for them to do so, there must be other forces defining the indifference level, such as labor market supply and demand factors, other than a payroll tax. Thus a payroll tax need not be as high as the cost of insurance in order to create incentives for employers to provide insurance.

Another option that is interesting to consider is offering private employers the option to buy into the Medicaid program on a sliding premium fee basis.

A very large portion of those who are privately insured, but are grossly underinsured are those who have to buy nongroup or individual insurance. This insurance tends to be very costly, and often covers hospitalization but does not cover outpatient ambulatory care.

Here again, there are several options. One is to facilitate a Medicaid buy-in and allow these folks to buy into Medicaid. Many of these folks are self-employed or uninsured and not all of them are poor. We could use individual tax credits or increase tax deductions for the self-employed, or we can set up a State level insurance fund, which provides insurance as a last resource, but enables those who now have no choice but to buy high cost individual limited policies to buy into a group which is essentially a State-wide group. An approach West Virginia has been considering using is its public employee's program as the basis program.

On the public insurance side, there are a few things that can be done with Medicare—the most important, probably, is to decrease the waiting period for SSI eligibility. On the Medicaid side, there really are two basic choices. One is to significantly expand the Medicaid program—and the first three options describe that. A second basic approach is to think about phasing out the Medicaid program—to maintain the Federal/State match as a form of financing. Under the second approach, if we have a national program, we would enroll Medicaid eligibles into State insurance programs so there would be no differentiation between those who are there by virtue of welfare and those who have higher income. Or, if States adopt a State insurance program before the Federal Government does, we could allow these States to fold their Medicaid programs into their own State insurance funds, thereby converting their Medicaid programs into a source financing subject to a maintenance of effort requirement.

An additional point under the Medicaid program is to improve provider reimbursement. We know that in many States the low levels of reimbursement, particularly for physician services, are an obstacle to their participation and a barrier to access.

On the publicly-financed programs, obviously we want to maintain as much of the State and local participation as possible. A great deal of the job is done by these agencies. Some of it could be reimbursed through an insurance mechanism.

But in our view, we believe that—even under a universal insurance program—there is going to continue to be a need for these programs, focused on groups unlikely to benefit from expanded insurance. Those are really of two types—those where the costs are extremely high—trauma, burn patients; and also a large number of persons—particularly the homeless, but also a lot of low-income people—for whom an insurance card does not help them to negotiate the system where additional services, like transportation outreach, and education are needed, but where you would not want to build that into an insurance system.

So some additional direct financing is going to be required. It would be, in our view, a big mistake to eliminate that.

Finally, the private voluntary system. We know a great deal about what hospitals are doing; we know virtually nothing about what physicians are doing. There is really a need for some health services research in this area to find out what burden the physicians are carrying, how that may be distributed and perhaps some mechanisms to distribute the financing burden more fairly.

We need to continue to provide compensatory financing for those providers—hospitals and physicians—who are providing a disproportionate share and who are thereby disadvantaged in a price competitive market. And finally, it seems to me we have to create some consistency if, indeed, we want to rely on the private voluntary system. We need to preserve those resources that are in place stimulate them by recognizing the tax exempt status for worthy institutions.

Clearly this is a presentation that is not designed to simplify—provide a very simplistic picture of the problem that faces us. Indeed, my role here today has been to try to reveal some of the complexity, but also to say that there are analytical models that enable us to relate these very important parts of the system in ways that do provide a holistic way of viewing it.

And again, thank you very much, Mr. Chairman.

[The prepared statement of Mr. Lewis appears in the appendix.]

Senator RIEGLE. Well, thank you. This is very valuable testimony and it helps us form, if you will, the parameters of this problem and our alternatives.

Let me yield now to Senator Durenberger.

Senator DURENBERGER. Larry, I agree with you in saying the emphasis needs to be on primary care, ambulatory care and so forth. It is pretty hard to construct a program that will give you that unless you say, we are going to mandate benefits. The only benefit we are going to mandate as you stated is—primary care and ambulatory care and you'd leave everything else as an add on.

But it seems like most of the proposals that I have seen go beyond that and they put in the physicians and the hospitals, like Senator Kennedy's proposal. Would you recommend that as we talk about national health insurance, or whatever we are calling this, that maybe we should just stop mandates at primary care and some definition of ambulatory, and leave the rest to be negotiated between employers and employees on some basis.

Mr. LEWIN. Well, that is a difficult question. As you may know, Senator, I am chairing an Institute of Medicine committee on substance abuse treatment that the Congress has asked for, and it sows an excruciating question for me because I see the ravages that have resulted because we have so little coverage of substance abuse treatment. But I do think that as we move forward towards a basic plan, there is a need to be disciplined on focusing on what is really the most important—what is the most critical.

I do not believe it is all primary care. I think primary care has been overlooked and its importance understated, particularly for children and adolescents and pregnant women, where I think it is the most important. I do not have a particular formula that I would recommend in all cases. I think it is something that requires more work. But the thing that is the most important, I think probably the greatest challenge to this Committee and other members of Congress, is to see whether we can—assuming we can agree on what is an appropriate minimum package—find ways to develop the trust of the business community and the insurance community, as to what will be mandated, and what will be negotiated.

Senator **Durenberger**. Let me get to the heart of what I am trying to ask you about. I heard Senator Kennedy's admonition about not reaching too far and let's be practical and let's just deal with what people understand. But in the next 24 hours or so, everybody here is going to have to vote on a proposal by the Chairman of this Committee to supplement an existing health insurance system. By the way, I did not see anywhere in your very thoughtful paper, the notion that one of your recommendations is that we ought to just supplement an existing health insurance system without any kind of test of what kind of coverage it provides.

What bothers me is the dollars. I mean it may not bother Senator Kennedy, but it bothers me a lot. Because, you know, everybody talks about the 11.4 percent and we are going to 15 and so forth. And as long as it seems like the system is out of control and you are paying more than your fair share of it, people seem not to pay attention to their personal responsibilities for dealing with it. So it seems to me that the missing link—as we talked about this last week when we had the Canadians and others in here—and the missing link in their system and the missing link in our system is some way to manage access into that system, so that you can have a richer set of benefits as Senator Kennedy proposes, with physicians and hospitals and all that sort of thing.

If you know that people are going to take the primary and not just skid over the primary—do not skip over the ambulatory and wait, you know, and rush down to the $1200 a day hospital or the $1500 admission emergency room, and skip over all of these inexpensive areas.

Mr. **Lewin**. Senator, if I may, I think there is a helpful way to think about this. We have acute care medical services, which have traditionally been financed with a mixture of co-payment and deductibles. We do this in part to create obstacles to excessive use.

There are some services, like primary care and preventive care, where we do not want any incentive to limit use. Therefore, I would suggest that those be treated without deductible, or co-pay where we are specifically trying to create incentives for their use.

By the same token, there are other services where there is the potential for abuse, for unnecessary use, or where our ability to set standards for spending or controlling care are limited. For those I think we can again differentiate and treat those with either more managed care overlays or higher deductibles or limits on duration and or scope of service.

So, instead of thinking about a package of services that we would treat homogeneously, using deductibles and co-pay, I think with that kind of three-part differentiation, we can begin to move toward solutions of this issue; thereby covering more services but covering them in different ways.

Senator **Durenberger**. Thank you very much.

Senator **Riegle**. Thank you, Senator Durenberger.

Senator Rockefeller.

Senator **Rockefeller**. Just one question, Mr. Lewin. You used the word "Christmas treeing" and I understand that. But that is in the eye of the beholder, wherein is the problem. For example, mental health, it just seems to me that generally that gets left out. There would be some who argue that health problems can relate to stress in an inordinate high percentage of instances.

My question really is not so much the merits of mental health benefits and whether or not they get paid for, but whether you think there is an appropriate way to decide. How do we do this? Do politicians sit down and decide what ought to be included? There has to be some kind of a core service group that is in the package. Do we do that? And what about mental health?

Mr. **Lewin**. I think that legislators need to decide what services should be covered, with broad guidelines. And using the third type of distinction that I have suggested, namely where you have various kinds of controls that you might impose, you can then allow some flexibility to the States or to whoever the insuring agency is to use those tools.

My own personal view is that with that kind of approach, it is not necessary to exclude what I consider to be vital services like mental health and substance abuse and care for the developmentally disabled children or chronic care management. I think that we are developing rapidly the tools to be able to manage those services more effectively. If we do not have those tools, then let's simply put limits on how much we will pay for if we need to do that in order to maintain actuarial soundness.

But to eliminate them from the package, in my personal view would be: unnecessary and a tragic mistake.

Senator **Rockefeller**. Thank you.

Senator **Riegle**. Thank you very much. Mr. Lewin, we again appreciate your important testimony today and we will stay in touch with you as we go down the track because we are going to want your thinking as we move ahead.

Mr. **Lewin**. Thank you.

Senator **Riegle**. Let me now invite to the witness table the Honorable Paul G. Rogers of Washington, DC, former House Member, and the Honorable Robert Ray, who are co-chairmen of the National Leadership Commission on Health Care.

Senator **Rockefeller**. As well as a former great Governor.

Senator **Riegle**. We are going to need an additional chair, I think. We want Mr. Rashi Fein to also come forward from the Harvard University School of Medicine; and Mr. Carl Schramm, who is the President of Health Insurance Association of America. I am wondering if we can accommodate everybody at the table here. We have sort of a short table.

Mr. Simmons, let me do this, I do not want to disadvantage anybody, but we did announce who the witnesses were to be and so that everybody is seated at the table, I am going to ask you if you would be the person that sits to the side or one step back so that we can have our invited witnesses at the table so they can get to the microphones. Otherwise, we are going to have people moving around and there is really no point to that. In the Senate Banking Committee we have a much longer table so it is a little easier to accommodate a larger number, but I want to stick with our program here.

Let me say to former Governor Ray of Iowa, and to former Congressman, Paul Rogers, we are particularly appreciative of the hard work that both of you are giving in the leadership on the National Leadership Commission on Health Care. That is very important work and a continuation of the kind of leadership both of you have shown in your respective parties over many long years. So I consider you to be particularly distinguished witnesses and I am very proud to have you before the Committee today.

STATEMENT OF HON. ROBERT D. RAY, CO-CHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE, DeMOINES, IA

Mr. RAY. Mr. Chairman, thank you very much. May I reciprocate by saying it is wonderful to have a person in your capacity who has shown so much interest in this very vital subject, I think the most important domestic issue in the country today, and we appreciate that.

To you, Senator Durenberger, I listened carefully to your comments about how long you are going to stay. As a neighbor, I hope you stay a long, long time. To you, Senator Rockefeller, a person with whom I served when we were both Governors, it is always nice to see a Governor make good, and I congratulate you on that.

We did not know we were going to have a crowd of people out here but that is welcome too. It is always nice to be with these gentlemen.

We note that the topic for these hearings is proposals to provide health insurance for the uninsured. I think that title itself says a great deal about the rapid change that is taking place in this critical area of public policy. You have our written statement. So I am just going to brush stroke it.

I would tell you a little bit about what the Commission found in the way of the problems. You have heard much about it this morning and obviously you people are schooled in the problems in this area. Then Paul will tell you briefly exactly what the National Leadership Commission on Health Care Plan and Proposal is.

You said, Mr. Chairman, and I am quoting, that "Affordable health care should be available for all Americans and their families." The Commission unanimously agrees with you. It believes that. Three years of close examination of the current American system has convinced us that we cannot achieve that goal with our present health care system. That goal is attainable only with a major restructuring of health care in America.

After careful examination, we have concluded that our health care system is undermined by three major and overriding problems. They are: (1) rapidly rising costs, (2) diminishing access, and (3) serious problems in the quality and appropriateness of medical care. These problems are interrelated. They are systemic and they are growing worse. Without systemic reforms it is very unlikely that we can solve them.

It is a cruel paradox that the most expensive health care system in the world denies access to millions of Americans because of inability to pay. This is happening at a time of rapidly expanding physician supply and while on any 1 day almost 35 percent of our hospital beds are empty. Of those 37 million uninsured that we have talked about this morning, over 11 million are children. And I keep hearing the great concern about them, rightly so.

That means that with those who are uninsured and, roughly, an equal amount who are underinsured, one out of four Americans has a very serious problem of access to the health care system. The second problem is rapidly rising costs, which have been rising at a compounded rate of 10 percent a year, reaching over $600 billion today, from $500 billion just 2 years ago. At this rate, health care will cost the nation $1 trillion in 1995 and $1.5 trillion by the turn of the century when it will cost $5,551 for every man, woman and child in this country. At that rate, by 2005 Medicare alone, as Senator Rockefeller said a few moments ago, will succeed social security payments.

The tremendous increase in Federal outlays has made health care a major contributor to the Federal deficit. And despite this high level of expenditures, Medicaid now covers less than half of those in need. American industry, which pays even more than the government for health care, will see its costs double and quadruple as well. This has led the National Association of Manufacturers to name rising health care costs as the greatest threat to American industry's economic vitality and its ability to compete.

The third area of major concern to the Commission is the quality of care. I was Governor at a time when some studies were first initiated which showed me the variation of procedures, and they could not be explained by differences in disease or outcomes. I just could not believe it. Since then, and during the studies of the Commission, we found some work that was done, especially by Dr. John Wennberg, that shows some great variances from different parts of the country, and different counties within a State, and between different types of procedures. That, too, is shocking.

It is shocking to learn that if all of the country's costs were the same as Boston for medical care, that portion of our gross national product that goes for health care would be 16 percent, not 11; and if the country were like New Haven, CT, it would only be 9 percent.

Dr. Don Berwick of Harvard has pointed out that the cost incurred due to the absence of quality control could run as high as 30 to 40 percent. The Commission has found that these three critical problems are all related and are exacerbated by malpractice costs. I am not going to go into the details, but the Commission report deals with malpractice also.

The report of the National Leadership Commission calls for a major restructuring of the American health care system. We simply believe that if we are going to have universal access, which we call for, we have to also deal with quality and appropriateness and cost. There are two-thirds of those people who are uninsured who are working, or are members of families who do work, where the bread winner can afford some type of coverage. In our plan, everybody would be covered, no one would drop through the cracks. But everyone would have some responsibility to make sure that he or she, and their families, do have some coverage.

We have a multiple choice for ways in which that universal access program can be effective.

I am going to defer to Paul Rogers who will tell you just briefly what this plan proposes and how we propose to finance it.

Congressman.

STATEMENT OF HON. PAUL G. ROGERS, CO-CHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE, WASHINGTON, DC

Mr. ROGERS. Thank you very much, Mr. Chairman and members of the Committee. We are pleased to be here.

What we are suggested really is a private sector-governmental partnership—a new approach. We are not taking the Canadian plan or the English plan, it is strictly an American plan, and I think that is what this Committee needs to address. Let us make our own plan as it meets the needs of our people.

Access. We call for access. That is what you are concerned with. We put more responsibility on the individual and this is set forth in our plan, to begin to let the individual to know he or she has some responsibility. For the most part, if you go out and drive a car, you have to get insurance. We put that responsibility, generally, on individuals. You should have health care. Why shouldn't it be some responsibility of yours? We talk about everybody else doing it.

Now we make sure that person will get health care. We give them some options. They can get it from the employer. And you may want to consider part of Senator Kennedy's plan then, for the employer to cover the employees, otherwise, they can buy it themselves if they have the resources—that is the second way. If they are under 150 percent of poverty or if they cannot get insurance any other way, they can go into the universal access plan that we call UNAC. Which, in effect, is run on the State level and you have the Medicaid pools which can be joined by other people.

Within a State, the fees are negotiated to help bring down costs within that State. This is a negotiated fee with the medical profession. Industry in a State can join UNAC, but they must join at the beginning of the negotiations and not wait and see whether that is what they like.

So this begins the process then of covering everyone—universal access. Now we think, and I know determined by your questions today, that you are concerned about costs, too. We have got to be. We are the greatest debtor nation in the world. Now we think one of the major factors to reduce costs will be to do something about quality.

It has been estimated that we can have from 20 to 30 percent savings if we would set up guidelines of practice. We simply have not done the research. Right now, I think it is interesting to note, 70 procedures done by the doctors of this nation account about half of the Nation's health care costs. Most of those procedures have never been researched; we do not know the answers. We set forth example after example.

This is something you really ought to look at. Suppose you save 5 percent from research on how to do things—cut out unnecessary care, inappropriate procedures—5 percent of $600 billion right now is $30 billion. That will about pay for the cost of the increased numbers you want to bring in in your access program. It will take a little while to do it, but it should not take too long. If we begin to get these guidelines, it also will help in the purchasing of care, because people will know better what they ought to be buying and what they should be rejecting.

So we think it is essential that along with access we have quality improvement and research, and cost savings brought about by that with your negotiated process that you would have on the States and, of course, improvement on malpractice. There is no point of sweeping malpractice under the cover. It has to be addressed. It is inherent in the whole system. That is why so many procedures are done. We kind of close our eyes to it.

Now some States have already taken steps to do something. We are recommending that we look at what has happened there and we begin to push statewide or even Federal initiatives if necessary. So we might as well look at the cost. It has got to be faced. We have got to look at quality. And we certainly all want access. If you expect to accomplish this, it has got to be done systemically. Because if you just provide access, you are going to have costs multiply even faster than they currently are and you know they are going to reach a trillion, 500 billion by the year 2000. Impossible.

So we have got to do something and begin to address the problem. We think we have suggested things. You may not want to take them all. But we out to begin to make change systemically and it can be done. Even the AMA says we ought to do something about quality. They have already started negotiating with the Rand Corporation for them to do the research. We know it can be done, and this is the approach the Commission thinks we should have—a systemic approach, Mr. Chairman, which will help us address all of the problems. I wanted you to know we are getting great reception from industry, from labor, from consumer groups, and may I say even from the Congress itself. So we are very much encouraged that people are willing to consider this idea of a systemic approach and this Committee certainly could help initiate it. And with the Rockefeller/Pepper Commission, too, probably looking at this, if you all join together and with Senator Kennedy, I think you could get something moving.

Thank you very much, Mr. Chairman.

Senator RIEGLE. Thank you very much.

We had an opportunity to discuss some of these matters in a meeting in Senator Bentsen's office recently.

Governor Ray, let me just refresh my memory. How many terms did you serve in Iowa?

Governor RAY. I have five terms, but that is 14 years, only two of them were 4-year terms.

Senator RIEGLE. Well, it is a terrific record. I remember back in my days in the Republican party that I thought there were too few of your kind of Republican around. I think there is even fewer today. But I have always been a great admirer of yours. I just want to acknowledge that.

Governor RAY. The Republican party is still alive though.

Senator RIEGLE. Well, in a manner of speaking I would say.

[The prepared statement of Governor Ray and Mr. Rogers appears in the appendix.]

Senator RIEGLE. Dr. Fein, we are very pleased to have you today and would like to hear your comments now, please.

STATEMENT OF RASHI FEIN, Ph.D., PROFESSOR, ECONOMICS OF MEDICINE, HARVARD UNIVERSITY SCHOOL OF MEDICINE, TESTIFYING ON BEHALF OF THE COMMITTEE FOR NATIONAL HEALTH INSURANCE, WASHINGTON, DC

Dr. FEIN. Mr. Chairman, I filed a statement which I hope will be part of the record.

Senator RIEGLE. We have it and we will make it a part of the record.

Dr. FEIN. I have tried to condense it to one page, but I must warn you, it is quite a page. I will be quick and I hope I will be brief.

I want to just begin by noting what everyone else has noted. I started in this field almost 40 years ago when I had my first Federal employment as a staff member of President Harry Truman's Commission on the Health Needs of the Nation, back in 1952. I think we are closer today to a serious discussion, debate and dialogue on this issue and to the enactment of legislation than we have been at any time in those almost 40 years.

What I have tried to do in the statement is stress the fact that there are really two issues. One is the equity issue of the millions of Americans without insurance. That is a moral issue. The other is the issue of costs, which affects our ability to compete effectively. We have simply got to control health care costs in order for the American economy to be able to survive effectively in world competition, and in order for the existing health insurance programs to be able to survive, let alone embark on new ventures.

If we do not control health care costs, any of the programs to extend health insurance that we might enact in this Congress or in subsequent Congresses will ultimately go down the drain and fail. A stable solution requires that we address both things. I would like to point out that a number of States, individual States, are, in fact, trying to do that. Their difficulty is that they are not receiving sufficient assistance through legislation from the Federal government and I would like to come to that a moment later.

We believe at the Committee for National Health Insurance that we have crafted a program that does address both problems. It provides a role for the Federal government; it provides an important role for State governments; and it provides for various elements of the private sector. It is not a centrally controlled program. It is a program that involves a mixed approach and that permits us to build on the existing programs that we already have in the United States.

Let me very quickly try and illustrate some of the responsibilities that evolve onto these various sectors. The Federal government would have the responsibility of defining the benefit package. I think that Senator Rockefeller's question to Larry Lewin was an important one. You will recall that he asked Mr. Lewin whether or not this is a job for politicians. I think it is a job for legislators, for politicians. I believe and the Committee joins me in believing firmly that civilian control over the profession, as civilian control over the military, is a necessary responsibility for government to assume.

So that we would look to the Federal government to define the benefit package. We would look to the Federal government to require the individual States to achieve various goals in cost containment, in quality enhancement but we would expect that the Federal government would permit, would leave, would allow those States freedom to decide how to reach those various goals. We would expect the Federal government to provide part, but not all of the funding necessary to expand services to parts of the population now receiving inadequate care and we would certainly look to the Federal government to mount assessment programs and technological evaluation programs that would benefit the entire nation.

States. We would look to the States to enroll the population, to administer the program, to define a State health budget a necessary prerequisite for cost containment to erect specific and detailed cost containment programs and quality containment programs. But we would permit and I want to stress this. Because I think that this is the new part of our proposal, one of the new parts. We would permit and encourage the State to enroll populations in whatever mechanism, through whatever mechanism, seems appropriate within that State.

It might involve mandating employers to do things. It might, in a given State, involve shifting a larger responsibility to the tax system. We leave that to the State. We require the State to make certain that every individual, who resides within that State, has the basic benefit package that has been defined by the Federal government.

Let me spend a moment on enrollment and funding. I want to stress States can tax and enroll. We would expect most States to try and encourage individual employers who are not providing insurance to do more than they can. And, therefore, we do set some limits on cost sharing, not unlike the limits that have been cited previously. We do expect that the States will provide an important role for insurance companies; and we would expect that individuals could continue in familiar relationships with particular insurers.

Finally, however, we do expect we would require that States use, for the purpose of insurance, community rating, and that for three very, very easily stated reasons: (1) We want to prevent employer discrimination against individuals who employers feel may be more costly, of higher risk; (2) we do not want to penalize older firms who have an older work force and who are paying higher premiums for the same benefits simply because they have been in business a long time and have an older work force; and (3) we want insurers to compete around administrative efficiency, not around the issue of who is best at selecting low risks.

Those are the essential features of our program. Obviously, there an awful lot of details. On many of those details we would have agreement with various individuals who have spoken and who will speak and testify today. We are encouraged. We are not interested at this point in disagreeing with anyone. We are encouraged by the fact that everyone wants to put forward their ideas and we feel that that helps stimulate the debate.

I would close with one appeal. Not only is it important that we enact this because of the scenario we could paint for the future. If we fail to act, it is a dismal one indeed. But I want to remind you that the individual States, as I noted earlier, are trying to meet these problems. They cannot do it alone because no State can feel comfortable in stepping out too far ahead of its neighbors.

It would be of tremendous benefit to the individual States that are trying to enact legislation, that are considering legislation, or that have appointed Commissions to develop legislation, to those States that are meeting together to discuss this common problem, if the Federal government would assist them by requiring all States to enact programs to ensure that everyone within those States has the basic package that is defined by the Federal Government.

I thank you.

[The prepared statement of Dr. Fein appears in the appendix.]

Senator RIEGLE. Thank you very much.

Before we call our next witness, I am wondering for testimony which, if any of you, would have the answer to this question or maybe my colleagues would as well. That is, do we know what percentage of doctors, for example, would earn more than $200,000 a year? Would anybody just know that figure?

Governor RAY. You mean presently?

Senator RIEGLE. Yes.

Senator DURENBERGER. I know they are all in Chicago this weekend.

Governor RAY. I do not know, but we will try and get that figure.

Senator RIEGLE. Dr. Fein, do you have any sense for that?

Mr. ROGERS. I do not have any feel for that.

Senator RIEGLE. Does anybody have any data along that line, in terms of who might, say, earn above $150,000 a year in annual income, or above $100,000? I mean, are there any generally cited

Dr. FEIN. Above $100,000, we know the mean income now is about $102,000; isn't it?

Governor RAY. $113,000.

Dr. FEIN. $113,000.

Senator RIEGLE. $113,000. So the mean income, would that be for 1988?

Governor RAY. 1987, I believe.

Senator RIEGLE. 1987. So that is out of date. But in any event, $113,000 a year in mean income, that would mean that half the doctors in the country were earning less than that, half more than that.

Governor RAY. That is right.

Senator RIEGLE. Do we know anything about the average?

Dr. Fein. The average is less than the mean. But I do not know how much less. The data that are kept by HCFA and by others would be mean.

Senator Riegle. Is it your sense that we have a fairly substantial number of doctors that would normally earn more than $200,000 a year? Is that a rarity or is that quite common?

Dr. Fein. There is something I think, Senator, between rarity and quite common. [Laughter.]

Dr. Fein. I think that is about where it falls. There are in every in many large urban communities a number of professionals who from their medical practice alone, not including any investments in other things, and not, of course, including their investments in medical supply companies, et cetera, earning over $200,000. They tend to be concentrated in certain specialties. It is my understanding that with changes in the relative value scale the number might decline somewhat, or in any case, not continue to increase.

Senator Riegle. Well, let me just cite what data has just been handed to me by the staff. Apparently the AMA has done an assessment of this and publishes data. They indicate the distribution of physician net income, after expenses, but before taxes in 1987, was $132,000. This was the mean for all physicians. Though this is not $113,000 it is in that general ball park, but it is certainly higher.

Now that is 2 years old. That is 1987. My guess would be that it is probably substantially higher than that. I would assume, with the mean at $132,000, that we would have what I would consider to be quite a large number of physicians above $200,000. I would think that it is at least 10 or 20 percent, maybe more than that. If this is the mean for all physicians in the country then it takes all the rural areas and what have you into account.

I say that, not because those are not terribly important skills, obviously they are, and certain kinds of medical skills are obviously life saving skills to many people. But we pay the President of the United States up in that range, in the low 200,000's and we consider that an appropriate salary for somebody who is doing the most important job in the country, I would think, by any fair definition maybe the most important job in the world.

So it seems to me, related your point of the question, Dr. Fein, as to what the cost structure looks like for procedures and what have you, that individual salaries or income is just one aspect of it. Obviously, we want physicians working hard, performing services, doing good work and so forth. But it seems to me that when we start looking at what the cost of—or what the income structures look like, it does raise important questions. It raises the important questions of what is sort of the motivational structure.

I mean it is hard to generalize in these areas, but it might well be that maybe we need to think about how we get more people to come into the professions. Maybe there are a lot of people around the country that might like to be doctors and earn half this much because they would like to do that kind of work like to save lives, like to treat people, and so forth. Maybe we are going to have to do something about figuring out how we bring the costs of some of these services down to lower levels.

Dr. Fein. Senator, if I could just interject. The most recent issue of the New England Journal of Medicine has a letter to the editor which you may want to read. I do not think you are going to enjoy reading it. It is from a young man who applied to medical school and was admitted to a number of medical schools who had been working in a poverty area as an assistant teacher, and wanted to become a pediatrician to continue working with those kinds of children, and who concluded that he had to reject the opportunity to go to medical school because the debts that he would incur going through school could not be paid off serving that kind of a population.

Senator Riegle. Well, that is what——

Dr. Fein. I think it goes to the point that you are making.

Senator Riegle. Well, that is my concern. Again, if you look at this data. It breaks it out by types of doctors in the general or family practitioner category. The mean income for that group in 1987 was $91,000; and yet when you get up into the more exotic skills areas surgeons, $187,000 was the mean; radiology, $181,000 was the mean; anesthesiologist, $161,000 was the mean. Now this was 2 years ago.

So my hunch is that these numbers have jumped up probably measurably in the period of time since. But when you just start looking at the cost structures, for example, cost of service structures, that data on its face, I think, tells us that this is a part of the problem we had better take a much closer look at.

Dr. Schramm, you are our next witness on this panel. Let us hear from you now.

Senator Durenberger. Mr. Chairman, before Carl speaks I am still not clear where you were headed with that line of questioning whether the problem is that the salaries are part of the cost system and, therefore, exorbitant I guess I would want to drag out the salaries paid the Washington Redskins, the Capitals, a whole bunch of other people against the price of admission to any of these games and a whole lot of other data in which Americans have distorted their values.

But I am not sure if that is the direction you are headed for.

Senator Riegle. Well, let me be more direct about it. I do not want to make the case for what the price structures are for sport stars. In a sense, we can decide whether we want to go to a sports game or not. I am not sure we can always decide whether we are going to go to the doctor or not when we have a major illness.

What I am concerned about is that costs are going through the roof. All the testimony today talks about this incredible rate of assent of medical costs in this country, and the percentage of GNP that we pay. I do not intend to target any one piece as a part from any other.

But I am concerned about the problem of the degree to which we may have a cost being higher because there is a supply problem. I would suspect if there were twice as many doctors in these categories performing some of these specialties, the prices would not be so high. The prices would be lower. Partly, because there would be more people doing it. It sounds to me like we may not have enough people in general and family practice and I think the data shows that, particularly out in the rural areas.

Senator **Durenberger**. Mr. Chairman, I would venture to say, if I can interrupt you, that that is the way it ought to operate, but it does not operate that way. In fact, we have a surplus in all those categories and the law of supply and demand does not work in medicine which may be part of your point.

I just wanted to be sure if you were moving in a different direction, which is that there is some problem in this country because the salaries are that high, that I would be able to suggest that it is our values in general. We do not put the right set of values on the things that are most important to us. And some of those people are world renown for what they have done for us. Some of them may not be so great.

But compared to an 18-year-old kid who is making a million dollars a year being a jock, I will take almost anyone of those guys first and women at their $182,000 salaries. I think it may be a values problem we have.

Senator **Rockefeller**. And, Mr. Chairman, if I can add on to that. Senator Durenberger and myself, and others, are working very hard in this whole concept of physician pay reform. I think you are going to see from that that in some of those areas where doctors are still most needed, and where they need to be rewarded more than they are, for example, primary care, general practice, that the so called relative value scale approach—which has now been voted on by at least one Committee in the House and which Senator Durenberger and I are looking at—could solve a lot of problems.

In other words, within the whole question of how do you motivate someone to want to be a certain kind of a doctor, pay does count. We are trying to address that.

Senator **Riegle**. Well, I think it is an important part of the discussion and it has come up two or three times sort of indirectly, if not directly, in the straight on sense here today in terms of our discussion. But I think it may be a mistake to, you know, reach for the sports analogies. There is a tendency to do that because, you know, baseball players who are making in some instances more money than the President of the United States.

I guess I put medical services in a different category. Because these are very important services that the country has to have. Just like the Armed Services. And, in fact, if there is a problem in terms of getting enough people out there who are trained and motivated to do the job, then we probably have a value and incentive structure problem in the country. But that is something we can fix. I think there are probably a lot of people in this country that would like to be doctors, and not necessarily because they would do it in order to earn $300,000, $400,000, $500,000 a year. Although some doctors may, in fact, earn that and earn more than that and be well worth it.

But when I see a health care system where health care is not even available to a lot of people, and in some cases what is available is very meager, as it is in some of the rural areas of Michigan, or some of the rural areas of Minnesota, or some of the rural areas of West Virginia; and then I see these kinds of fundamental embedded economics in terms of who is in the business and what they earn, there is something wrong there.

Maybe there is something wrong in professional sports, too, but that to me is not of critical national impact the same way it is if somebody needs a doctor and cannot find one in some out-of-the-spot place or the services for doctors' activities are so high that people cannot hope to have them. That we do not have to tolerate in this society. We have people who work in the Peace Corps for next to nothing, and they are proud to do it because it is important work.

I suspect there are probably a lot of people in the country that would like to be in the medical profession for reasons other than economics, and many are. But maybe we need to open the door up so a lot more get in.

Governor RAY. I was just going to add that——

Senator RIEGLE. I want to get to Dr. Schramm here in just a minute here.

Governor RAY. Physicians costs have increased 16 percent for each of the last 6 years. That is not affordable. But it is not always the rate for each doctor; it is the increased services and the testing and all the other things that go along with it. A great critical need is in the family practice in rural areas, like we have in our States. There we need more physicians. But it is much more difficult and we do not pay them enough. They are on the low end as you well know.

But I do not think it is necessarily true that the more doctors we get, the lower the rate. I think what we have found is, the more doctors we get, the more services we get, and the more testing we get, and the higher the cost.

Senator RIEGLE. Well, I suspect here that what we have is not a one dimensional problem but a variety of dimensions to the problem. But that is clearly a part of it, and I think a growing part. If we are getting rates of increase like that of 16 percent a year, you know, that is clearly part of the problem.

Dr. Schramm.

STATEMENT OF CARL J. SCHRAMM, Ph.D., J.D., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Dr. SCHRAMM. Thank you, Mr. Chairman; and thank you for having me this morning. I was beginning to get the impression you were dying to hear from the private insurance world.

Our member companies, 350 strong, cover 90 million Americans. Together with 76 Blue Cross plans, which cover about 83 million Americans we constitute the private insurance sector.

I would like to take a different approach this morning and offer something of an historic prospective in which we might settle some of what we have heard this morning. I think it is important, as Mr. Rogers has pointed out, that we are in search of an American solution. I do not think there is a quick fix from Canada nor should we look for a quick fix.

I think in the area of health policy we have been burned many times by "magic bullets" that we thought would settle the problem once and for all. I have the HMO legislation, health planning and other pieces of legislation in mind. I think really in 1965 we understood in rather sober terms that there had to be a public and private partnership. We went through the very difficult process of enacting a public access program for the poor and for the elderly—Medicare and Medicaid.

I think the architecture of a public and private sector program has basically been insinuated into every single piece of testimony you have heard today. I think the perspective of the private insurance industry has been, at least for the last 2 years, that the existence of 37 million people without health insurance is terribly indicting of our system of financing and it is unacceptable from any perspective that anyone might harbor. And, indeed, our job is to be a party to changing that and to come up with an offering that will repair the arrangement that we conceived of in 1965—a public and private partnership.

I recall in 1965 we fully understood, as a society, that some risks could never be covered in the private sector and the public sector had, for the first time in American history, been recognized as having an important primary role in financing care for people who were poor and elderly.

I think it is time we think about four things we ought to do to make the system work again, to clear away some barnacles that have come into place in the last 20 years, and to refocus on this private/public partnership.

The first offering we would make is that we must, in fact, reform and expand the Medicaid program to cover all people below the Federal poverty level, regardless of family structure, age or employment status. This means we have to eliminate categorical restrictions; we should uncouple eligibility from welfare cash payments; and I think we ought to think about the dynamics of poverty. Our offering is a program that permits a buy-in to primary and preventative care for people between poverty and 150 percent of poverty.

We have to permit a spend-down, such that people who are climbing out of poverty, if they have out-of-pocket expenditures that cause them and the family budget situation to again be impoverished, could have the State pay for the Medicaid program for them. And as people work their way out of poverty, employers and individuals would have the employee's share of the private premiums paid for by the State Medicaid program.

These changes in Medicaid would go a long distance to essentially making a dynamic safety net operate under the poverty population. One of the reasons there are about 35 million people uninsured, comes from the steady erosion over the years of our commitment to the poor. In 1976, 65 percent of the people below the Federal poverty level were covered by the Medicaid program; in 1986 that was about 40 percent.

The second component of our approach says, that we must allow insurers to develop and sell more affordable coverage. In order to do that, one of the first things we must think about is to examine the ERISA law and extend the preemption of State mandated benefits enjoyed by private self-insurers to insured employee plans.

We operate at an immense disability under State mandated benefit laws that make commercial insurance unaffordable for many marginal small employers. It is estimated that in some states, like

Maryland, with 24 mandated benefits, the cost of basic medical/surgical coverage is 20 to 22 percent higher than it would be absent those mandated coverages.

The third thing we would suggest is that the self-employed, their families and any employees should receive a 100-percent tax deduction for their health insurance.

And finally, we believe that we must establish some pools to deal with uninsurable individuals. We have fought strongly for the establishment of State pools. We believe if the State pool option is not chosen by States, that the Federal Government should set up pools in those States for uninsurable individuals.

For uninsurable groups, we believe that a private reinsurance mechanism, potentially chartered at the Federal level, and financed privately through equitably ridding the risks through both insurance companies and ERISA pre-empted self-insurance plans is what is required.

I would conclude by suggesting that there has been something surreal throughout all of the testimony I have heard this morning. While we have mentioned it, we have not focused on it. The fact is that we have at least 10 million Americans uninsured now that were insured a decade ago. It is my sense that one single factor—unchecked cost inflation in the provider market—is the reason why we have seen States evacuate their promises, the Medicare program evacuate its promises, and small employers finding the cost of insurance unaffordable. The net result is that the program we envisioned in 1965 is falling apart.

Thank you very much.

[The prepared statement of Dr. Schramm appears in the appendix.]

Senator RIEGLE. That was a very important statement by you and by all of the witnesses.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. Carl, if I can begin with you—and I have just had now to sort of look over this statement. It is, for me, kind of exciting. I mean, to see the way in which you have been able to integrate the Medicaid buy-in/buy-out deal with the ERISA pre-emption, deal with the uninsurables, and then provide some way in which we use the tax subsidy for the self-employed and so forth. That generally describes some of the basic elements of this plan; does it not?

Dr. SCHRAMM. Yes.

Senator DURENBERGER. It also keeps sort of the—using Medicaid somewhat differently, keeps some of the basic financial access decisions down at the State level, where the States have the options to do certain things and yet it looks like most of those options are driven in the direction of making available to people, all the way up to—what, how many——

Dr. SCHRAMM. Eventually 150 and we have even thought about 200 percent of the Federal poverty line.

Senator DURENBERGER. Okay. If I understood it, the purpose of your proposal is to number one, encourage people to work.

Dr. SCHRAMM. Yes.

Senator DURENBERGER. Which is the thrust of welfare reform, of the Family Security Act around here. Secondly, to provide benefit transition from when they could not work to the workplace.

Dr. SCHRAMM. That is right.

Senator DURENBERGER. Third, to provide some way in which the beneficiary will make what I think is called a nominal contribution to the premium.

Dr. SCHRAMM. Yes, as low as $6. 00 a month.

Senator DURENBERGER. Right. And then that in some way the employer's contribution to that premium will be on a sliding scale assisted by the Medicaid contribution to the same premium, right?

Dr. SCHRAMM. Yes.

Senator DURENBERGER. But the thrust of all of that, unlike Canada and some of these other countries, is that people, rather than buying doctors and hospitals, will be buying health plans or health insurance or whatever.

Dr. SCHRAMM. That is correct, yes.

Senator DURENBERGER. So, as I understand it, you recommend and have an apparent self-interest in this idea. But rather than having certain kinds of public facilities for people who cannot get their service somewhere else or having certain kinds of public programs, like Medicaid or Medicare, or the Indian Health Service, or a lot of other things for people who do not buy health insurance or cannot buy health insurance, your thesis here is that everybody ought to buy their way into universal coverage through the premium cost of a basic health plan. Does that generally characterize what you are talking about here?

Dr. SCHRAMM. Yes. I think it does, Senator. I might say just at the outset that the HIAA Board passed the elements of our proposal about a year ago February when we had the great good fortune and counsel to have Governor Ray serving on the Board of the Health Insurance Association of America. So one other panelist is fully familiar with much of our proposal.

We did attempt to integrate this into the language that is currently circulating in terms of welfare reform. We believe that the States should operate programs that are responsive to their needs, particularly in the goals of Cost containment. That is one of the abiding concerns we have with the notion of moving to federally mandated programs, that much of their benefit design would also be mandated. The federalized approach essentially, erodes what we know to be one of the key ingredients of the medical marketplace, its variability. There is not yet, and not likely to be for a long time, a national medical marketplace.

In fact, there are enormous idiosyncrasies. Governor Ray pointed them out in terms of contrasting what the GNP estimates would be if we were to use the per capita medical expenditures of New Haven versus Boston. I think your sense of this is absolutely right.

Senator DURENBERGER. You heard my question of Larry Lewin earlier about the benefit package and everybody struggles with that, and I am still struggling with it, too, as I hope was indicated by my question. But your benefit package is basic ambulatory—such as well child care and immunizations, prenatal care, basic diagnostic, laboratory tests, x-rays, primary treatment services, monitoring of chronic illnesses, outpatient prescription drugs, according to the State's Medicaid formulary.

Dr. **Schramm**. That is correct.

Senator **Durenberger**. And if I understand your figures correctly, you can buy that. You assume that that package can be purchased out there for the people we are talking about for about $50 to $60 a month for a family of three. Is that correct?

Dr. **Schramm**. Yes.

Senator **Durenberger**. So that it strikes me as kind of a deal we should not turn down too readily. Where did you get these figures? I mean, how does it come so cheap, so to speak?

Dr. **Schramm**. Well, Senator, that is for the preventive and primary care package. It is our estimate from our own experience and public Medicaid program experience, and we believe those to be accurate figures.

There is an awful lot of tinkering with numbers in these debates. It is our sense that providing the primary care and preventive package is in many respects the cheapest part of insurance.

Senator **Durenberger**. Even when you get up—pardon me, Mr. Chairman. I just have another question to continue this line of thinking.

Senator **Riegle**. Please continue, yes.

Senator **Durenberger**. You also contain on page 4 a sort of a sliding scale monthly premium charge by income. It goes from $6 a month for a family income at 100 to 109 percent of poverty up to $54 a month from 140 to 149 percent of poverty; is that not correct?

Dr. **Schramm**. Yes.

Senator **Durenberger**. Now let me just, for a moment, so to be sure I understand this, compare that. Well, let me ask you a different question, which is, is that the premium charge that the—the second thing I read there, the $6 through $54—that is what the family will contribute to the overall cost of a benefit that costs $50 to $60 a month. Is that right?

Dr. **Schramm**. That is correct.

Senator **Durenberger**. So that when you get right near the top there, at $54 a month, then you have just about paid the whole cost of the program which is somewhere in the $50 to $60 range?

Dr. **Schramm**. Yes.

Senator **Durenberger**. Okay. Thank you very much.

Dr. **Schramm**. And I might say that hinges on an arbitrary choice of 150 percent of the poverty level.

Senator **Durenberger**. Right.

Dr. **Schramm**. Some would move that upward.

Senator **Durenberger**. But the public cost is $50 to $60 a month and it is reduced for a person—that is up to 100 percent of poverty. When you get over 100 percent of poverty, the public cost, the taxpayer cost starts going down as the person's contribution reaches $54 a month.

I am looking right now at the distributional impact of the health insurance premium credit, which is a piece of legislation passed out of this Committee last week, designed, I think, to help these same kinds of people. At the level of $5, 000 of adjusted gross income the public cost, by way of a tax decrease, is $210. That is on an annualized basis, I believe. At the $5,000 to $10,000 level, it is $243; at the $10,000 to $15,000 level, it is $262.

Do you have a familiarity with the so-called Bentsen proposal? Are you familiar with that?

Dr. SCHRAMM. Not that I would like to comment on it.

Senator DURENBERGER. Not that you would like to comment on at this time. Well, maybe I will come back to this in just a second because I would like to get the views of the experts on this panel about comparing the product that we are going to be voting on on the floor with some of these excellent suggestions that we have had today.

Senator RIEGLE. I think that is a very important line of questioning and it is very valuable. I appreciate it. I have been called over to a meeting with the Majority Leader that I must attend. Senator Durenberger has kindly agreed to see the hearing through to its end.

Before I go to Senator Rockefeller, I want to acknowledge also that we are going to be hearing from Mr. Patrick Babcock, who is the Director of the Michigan Department of Social Services and Co-Chairman of the Governor's Task Force on Access to Health Care. I am especially pleased that he will be coming along just a little bit later. So let me now yield to Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I just have two questions. One would be for Dr. Schramm. You have a four-point proposal and obviously it deals with Medicaid. I have introduced what I would call an incrementalist type Bill, which would allow Medicaid to provide long-term care, home-based and community-based. That is kind of backdoor, so to speak. On the other hand, it does help a small section of the most poor and the most fragile in terms of their health.

You know, even as I do that, I feel good because I think the Bill may go through and George Mitchell likes it. I feel good about that. On the other hand, we are looking at Medicaid programs which are getting enormously underfunded. I worry about that. Because if one takes the incrementalist approach, one has to at some point really deal with Medicaid. Doctors now, in some places just will not take a Medicaid patient.

So that my question of you would be, do you have concerns that in your four-point proposal about buy-in that in fact people may be buying into, in a sense, a substandard insurance program? And if you agree with that, do you have ideas as to what we might do to strengthen Medicaid?

Dr. SCHRAMM. Well, Senator Rockefeller, to be sure, one of the premises of our proposal as regards Medicaid is that the public budget has to expand to cover old fashioned Medicaid, if you will. I think your question is absolutely correct. If we are to proceed with Medicaid as we have in the last few years, it will be substandard. It is substandard. It should not be substandard. I do not think what has happened to it was the vision of 1965.

The legislation on long-term care that you have been piloting seems to me reflects the basic vision of 1965. I think it is important to pause there for a second and think about long-term care and its financing as it is emerges as a national issue. It seems to me that the only reasonable alternative in a time of a very constrained public budget is to look right back at the Medicare/Medicaid public architecture of 1965. It appears as it there will be a very viable market for private long-term care insurance for people in the middle class—lower middle class—and certainly affluent Americans.

But as regards people who are poor and without means, there will never be a provider of an insurance product and that responsibility has to fall to the public sector. So I think in a sense long-term care as it is beginning to be thought through on the Medicaid side and the public sector side ought to provide a lever to reopen a discussion of how much Medicaid really ought to cost. So it is not a substandard program.

Senator ROCKEFELLER. One philosophical question to Governor Ray or Congressman Rogers. You addressed forcefully in your testimony the escalating costs. You know, it is dramatic. It is depressing, powerful testimony. Now, the business of cost containment is always easy to talk about then very hard to get anything done about.

In other words, if somebody comes up with new technology and if 50 percent of the cost of health care in an average American's life takes place in the last 2 months of that person's life, if that is the case, and I am told that it is, then that technology is important because it becomes automatically everybody's right. If there is something available, then let us all have a chance at it.

Not true in Canada. There may be an MRI machine, one per Province, something of that sort. They have a different way of doing it and people do not mind queuing up there. Those who do can come down here and get the service more quickly if they can afford it. In any event, it is easy to talk about cost containment and extremely hard to get something done about it.

Witness hearings that we have had on our Subcommittee on Medicare and Long-term Health Care, and on the whole question of physician payment reform, the President suggested, and I think properly, that he will not sign a physician payment reform bill unless there is an expenditure target as he puts it. That pretty much gets to the heart of it. In other words, you can adjust physician payment reform and make it more attractive to get into primary care, OB/GYN, or whatever, but at some point you have to deal with what you said, Governor Ray, in your testimony that costs are just going out of sight—bigger than social security pay out by the year 2005. I mean, that is just absolutely incredible. It is absolutely incredible.

Now when one actually addresses containment, however, there is a lot of resistance. The American Medical Association was here last week saying that they are adamantly opposed to any kind of expenditure target cost containment. They did say that practice guidelines could be useful. I would be interested philosophically in how each of you feel about how it is that one convinces the medical community that cost containment is going to have to take place, number one, and how you think practice guidelines, as opposed to expenditure targets might work.

Governor RAY. I think you are right on target. That is the reason in our prepared statement we dwell considerably, and I hope forcefully, on the fact that you cannot solve this problem if you deal only with access. As a matter of fact, you cannot solve the whole problem if you deal with any aspect of it; you have got to deal with all facets of it.

We happen to believe that when 20 to 30 percent of the health care in America is unneeded or inappropriate and sometimes harmful—you are talking about $120 billion—and that can be stopped. There is good, solid evidence that physicians and providers will change their behavior if they have valid information, good data to show that there are better or different ways in which they should be practicing. So that is number one. We deal with standards or guidelines or parameters or whatever you want to call them, that we believe the medical profession needs and is ready and willing to accept. That would be helpful.

We mentioned the variances studies. It is just unbelievable the difference between different communities, the way in which professionals are practicing. So if we can change that, and cut out a lot of the unnecessary procedures and care and waste, then that in itself will make a big difference.

Senator ROCKEFELLER. But how does one do that? I mean, how does one—one cannot simply, you know, trot off to New Haven and Boston and have door-to-door visits with doctors to change their behavior. I mean, how does one do that without some kind of a set standard which forces that change.

Governor RAY. The standard makes a difference and secondly, the dissemination of valid information, so that doctors can see there are new or different procedures, or different methods to follow. Like I said, there is evidence that they will follow that. They will make changes. You cannot hit them over the head with a two-by-four and expect them to do anything but defend their position. But if you give them good valid information, then they will adjust and modify accordingly. That is just one aspect.

Mr. ROGERS. I will be very brief.

I think there are a couple of other things that may help, although you may have to do all three of them, including your cap on costs. Certainly, in an interim basis, to begin to slow things down, you may have to do cap cost until you can get education out to the profession and to the buying public on what we should do.

I think we must do the research, and that also goes to new technology, to make sure that we know what that new technology will accomplish before it is brought into the system, just as we would do on the clinical practices of the doctors. Then if we get that information disseminated—and as you know, there is already information—I mean, there is already legislation that has been introduced to begin that process. And, in fact, HCFA is already doing research in that line. But if we can get the information out, it will have an impact.

In Maine, where they did the research with proctectomies, as soon as that information was gotten out, they had a drop in the use of that procedure of 15 percent. Well, if that went nationwide, that is a considerable amount.

Senator ROCKEFELLER. Who put out the information?

Mr. ROGERS. The researchers and through the profession itself in Maine. Now that can be done. It has got to be a national effort and that is what we recommend in our proposal.

Senator ROCKEFELLER. On the other hand, you are also saying that medical malpractice is driving—I mean, I assume in the 23 percent of unnecessary procedures of the $150 billion, it is not all just what I want to do, it is as a doctor, it is what I feel I have to do to protect myself.

Mr. ROGERS. I am sure that is part of it. So that needs to be addressed as well. But also, we need to begin—and we call for this—an education of the public on dying. This really needs to be addressed. That can be done. Already you are hearing more and more in every State about living wills, that they do not want to be kept alive when they will not have any quality of life, and we need a real program of education on that.

So that is why we are saying that all of these problems need to be addressed systemically. You just cannot take one and expect to solve it because they are all so intertwined. I think the cap will certainly put an overall budget level, but a lot of costs will shift over to the private sector from the government sector. That will happen. So we also need the research on quality and to set up some guidelines which will also help in malpractice. If it is a nationally accepted procedure, that will be a more helpful defense for any malpractice.

Everything ties together, I think, in these three areas—access, quality and cost.

Governor RAY. One other aspect of that is the pools that we recommend. I think most programs call for some kind of a State-wide pool. We would fold Medicaid into that pool, and all others who are uninsured would go into the pool. Anyone else could opt to join at a cost. The business of those pools would be conducted by providers, by insurers, and by business people, so there would be some balance. They would negotiate with the providers so that we would get a fair rate but not an excessive amount.

I think they would have the clout and the ability to make some difference. That, in itself, should be some guide for controlling costs. And, there would not be the need to shift those costs as we see them today, which is making the employers and business people just climb the wall, because everybody would be covered. Under our plan there would not be anyone that would not have some coverage. There would be options; they would have choices. They could have their coverage, the basic care package that Carl talked about. We would hope that those people would buy from the private carriers or from the carriers of health coverage. But if they did not, they could go into the pool.

Senator ROCKEFELLER. But Carl is saying, I think, that insurers would not have to contribute into that risk pool anymore. Am I wrong on that?

Dr. SCHRAMM. Senator, as regards the uninsured individuals, those pools would, in fact, be contributory and we would hope that the majority of the revenues would come from the individuals who would be paying at 150 percent of the average individual premium in the State.

But our experience is that virtually all of those pools are losing money and do need sustenance from State general revenue to keep them afloat. As regards the small group pool, we would hope that that would be totally sustainable from revenues from insurance companies that would participate in it, plus the extension of this obligation into self-insured plans.

Governor RAY. I think some of those that are losing money, I might point out, are risk pools. So the bad selection goes into those risk pools and they are not priced adequately. For example, they will pay 150 percent of the average cost for health care, yet they are using 300, 400, 500 percent.

So these pools we are talking about—I think we are on the same wave length here—are pools that would spread that risk across the board so that healthy people would be in there as well as the unhealthy ones.

Senator ROCKEFELLER. Thank you very much.

Senator DURENBERGER. Gentlemen, the issue of mandated benefits has not been talked about specifically. But I need to ask you a question in terms of what position you take. I know what position Senator Kennedy takes on State mandates. Let me just ask each of the three of you what your view is on restricting the ability of State legislatures to mandate coverage benefits here.

Dr. FEIN. Well, Senator, in the program that I discussed, we would permit the State to enroll individuals through whatever program it decided was appropriate for the economy of that State, for the politics of that State, for the demography of that State. I would hazard the guess that most States for clear and obvious reasons would prefer to use a program in which they call it mandated benefits—mandated employers to provide benefits—rather than adopting a program which would shift everything onto the tax program. They would not abolish that kind of insurance that employers now provide.

Senator DURENBERGER. I am sorry. I need to interrupt. I am not talking, Dr. Fein, about ordering—a pay order to start paying. I am talking about coverage for substance abuse, coverage for——

Dr. FEIN. Oh, I am sorry.

Senator DURENBERGER. In Minnesota it is hair pieces and things like this, whatever they need.

Governor RAY. I can only speak for myself now. But I think mandates are wrong. I think it requires many people to pay for services they do not need or that are not necessary. When we have a societal problem, I believe that risk ought to be shared by all of us in society and not those who have coverage for themselves or through their employers. I think it ought to be their prerogative to have the kind of program that fits their needs the best.

When you do that, the more mandates you get the more uninsured you get and the bigger the problem is. This seems to me to be a very poor way to try to solve a very serious problem.

Mr. ROGERS. Senator, it is my feeling that the basic package that would cover the universal access plan in a State as we have proposed it, really would be set here by the Federal government, simply to provide that the basic elements of that plan would be consistent throughout the United States. Now to add to that plan, I presume you would have to come here and everyone would have to be heard, if there is mandating.

But as far as the State is concerned, I think we said yes. Although we really did not go into this, we were talking about it. The State could manage it if it wanted to pay for it itself, but not to make everybody else pay for it in their own State. Let them, if they want to add a benefit that they want to provide to the people of that State. Then the State would have the obligation and not the Federal Government or those who are participating in the program.

Senator DURENBERGER. Okay. Thank you, Paul.

Dr. SCHRAMM. Senator Durenberger, I mentioned in my testimony the high costs of these benefits and cited Maryland. In the last 10 years over 700 mandate laws have been passed in the 50 States. California, New York and Maryland happens to lead the pack. Minnesota, as you point out, may be in some particular category with its coverage of hair transplantation, but California with herbal therapy is not far behind.

Our proposal is to extend the ERISA preemption to private insurance plans and to some extent, I hope that that would operate to dampen the impulse at the State level. To be realistic, it probably would result in the podiatrists and hair transplanters and others coming before you insisting on being mandated. It is our general analytic perspective and hope, however, that employers would be heard more loudly in the Federal forum than in the State Houses.

Senator DURENBERGER. Thank you.

Dr. FEIN. If I could just—now that I get the full context—make a comment or two.

I agree, mandating is not the best way to achieve progress in a society. But when I see legislators doing something which has at this table been defined as not a very good way to go, I ask myself, why do they do it. I would want to say a word on behalf of mandating. It is the expression, at State level, of legislative, political intent as it is impelled by the public.

I do not think that the public is as ignorant as is suggested. The public feels that certain benefits are important.

You and I may say at a moment in time that hair transplants are not, or herbal medicine—and I do not have any problem about laughing about herbal medicine. But I think the problem then is, why not educate the public to say no or the legislature to say no.

In general, it is not my observation that that which State legislatures have mandated sounds as foolish as the few examples that can be brought to the table. In general, it has provided important benefits for many people who otherwise would not have had those benefits through their health insurance programs.

Senator DURENBERGER. I do not want to take on that latter because we are running out of time. But I think I can explain to you, as somebody who has been in politics for a long period of time, why certain providers cannot convince all Americans that their services are very valuable. And largely, it is because of the presumption that people are not paying for them. In the specific, somehow they are getting them for nothing.

The problem that we all face is that—whatever it is—60-some percent of Americans, or 80-some percent of Americans think there is something wrong with this health care system of ours, that we have deprived everyone of them of the ability to determine what that is. So they tend to blame somebody else for it.

I would take it that the variety of mandated benefits in this country, the variety of benefits in this country, compared with any other country in the world is unique; that the variety of availability of these benefits, despite State mandates is unique; that if you work for AT&T versus working for some little company in some small town in Iowa or something like that is incredibly different; that some insurers, if we can believe the data, are very efficient in the ratio between what they collect in premiums and what they return in benefits, while others have been labeled at this time from time to time as rip-off artists and a variety of things.

So, in effect, that might say to somebody who was looking at the system that using insurance, or the insurance access into the system is not a very efficient way to go about running the system. I wonder, Carl, if you would not make the argument—I think I know where the Commission is coming from and Dr. Fein is coming from. I wonder if you would make the argument that given all of this history which I would say really is not insurance, it is just sort of health—you know, it is giving away certain benefits—make the argument that we ought to trust these private health insurance plans in this country to carry the burden of financing access for 37 million Americans.

Why, given all of this history, can we expect to find that particular vehicle for access better than going to some sort of a put everybody into a State pool and have people share a percentage of that pool or do a variety of these other proposals that have been made to us?

Dr. SCHRAMM. Well, Senator, our solution in fact envisions for some a financing mechanism that would involve State pools. But I think you are right. Your observation in response to Senator Kennedy was correct in the sense that much of this does not look like insurance. It begins to appear increasingly that people expect a dollar or a dollar plus back for every dollar they put into the system. The insurance concept that I pay in against a bad circumstance that might happen is largely eroded.

But, in fact, health insurance as a financing mechanism still continues to work very much as it has historically. I think the case can be made that if there is a fault it has been that we, private insurance, and Blue Cross insurance, along with Medicare and Medicaid, have not done our jobs in terms of making the system affordable enough, to ensure that everyone who was once under the safety net and needs it can continue under the net.

This points to what is, I think, the single overarching fact of the history of health financing in the United States the last 25 years. That is, with the entry of public payment on an access mandate, we all, for political reasons or what have you, failed to go back and revisit the economic discipline mandate that has to go along with it.

Senator DURENBERGER. So part of meeting this problem of the 37 million people is going to have to be to reconstruct some of the public policies that are behind the disparity that you see in a lot of the current coverage, I take it; is that correct?

Dr. SCHRAMM. Yes.

Senator DURENBERGER. I am going to wonder out loud and I have decided against asking specific questions of you with regard to the

Chairman's proposal because I am afraid everybody may react in similar fashion—you have not seen it. Most of the rest of us did not see it until a week or so ago either. But I am struck by the fact that anyone would want to spend $1. 4 bill ion of new dollars to just supplement an existing system in some way that everybody agrees is out of whack and that is sort of—people are bailing out of all of the time without doing some fundamental reform to that system.

I know the reform is difficult. I know it has to be incremental. I know that getting at the problems of young kids and young mothers and their children is incredibly important. But we have had before us today a variety of wonderful proposals for how to deal with that specific problem.

This Committee is all about families and uninsured. It is the first time this Committee has met. It has some wonderful people who have spent a lot of time with a lot of proposals for doing something about this problem. And yet I am struck by the fact that not a one of you, not a one of the people that we have heard today, and maybe we will get it in the next two witnesses, has said, what we ought to do is take $1.5 billion a year and supplement the existing system with credits for people who are already buying health insurance, so the credit can go to the low paid employee at AT&T to buy a $600 a month, first dollar, coverage plan and the same credits going to some person who cannot even use it because they are self-employed or they are in some small business where the plan costs them $200, $300, $400 to buy a third as much as they get at AT&T.

I cannot quite understand why anybody would make that their first recommendation, except that I know the Chairman of this Committee is getting very frustrated by the fact that those numbers keep getting larger all the time and we are not doing anything about it. I am sure the thrust of his argument is, let us at least take the existing system and use that to try to hold the line. I think this will be his argument—let us hold the line; let us not have any more people bail out on it; let us not have any more employers drop their coverage.

As I said, I am not going to ask any of you—unless you want to—to comment on it. Because I think we will have this debate on the floor. But I think everyone here has shown their appreciation of the fact that all of you have committed a lot of time to closing that gap and some very, very good suggestions have come from everybody on how to do it. I do not see anybody else here.

I thank you all very much for your contributions.

Now we will call Patrick Babcock, who is Co-Chairman of the Governor's Task Force on Access to Health Care and is also Director of the Michigan Department of Social Services; and Bonnie D. Post, who is Chairperson of the Commission, the Maine Special Select Commission on Access to Health Care and is also Executive Director of the Maine Ambulatory Care Coalition.

Thank you all for your patience with all of us. I know you both—I can tell now that both of you have been sitting through all of this and we welcome very much your being here today.

STATEMENT OF C. PATRICK BABCOCK, DIRECTOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES, AND CO-CHAIRMAN, GOVERNOR'S TASK FORCE ON ACCESS TO HEALTH CARE, LANSING, MI

Mr. **Babcock**. Thank you, Mr. Chairman. I appreciate the chance to be here, too. I am Pat Babcock, Director of the Department of Social Services, as you said, and co-chair of the Governor's Task Force on access to health care. A Task Force that Governor Blanchard appointed about 18 months ago—a 40 member Task Force, literally representing all facets of the Michigan community concern with access to health care. We will be making policy recommendations to the legislature in October of this year. That is why the last couple of hours have been helpful, Senator.

I would like to, today, cover a couple of points of our work on access and then share at least our thoughts at this point about directions at the national level, as well as the State, some of which you have just touched on in your last few comments.

First, I should point out that Michigan is relatively fortunate. About 88 percent of our citizens have private health insurance, compared to about 82 percent for the nation. But that is changing dramatically as we and the rest of the Midwest go through some major changes and costs to employers, job mix with the part of the economy growing fastest with that sector with the least amount of health insurance.

Fiscal pressures on government over the last 8 years, which really have resulted in reducing the public sector involvement for a number of people who in the late 1970s may have received health care through Medicaid or through other sources. And also, the issue of cost containment which while admirable in reducing the costs of health care have reduced the ability of the provider community to shift certain costs and have one sector subsidize another.

We are in the process of looking at a number of policies. But in the process of doing that, we have just completed a State-wide survey conducted by the University of Michigan and I have included charts within my testimony. Let me just touch on a couple of them because the survey really reinforces to some degree what Senator Kennedy and other individuals said this morning.

First, about 11.9 percent of our population under the age of 65 are without health insurance—nearly a million people. It is a young population, 32 percent are under the age of 18 and 57 percent under the age of 25. It is an employed population, with 67 percent having a connection to the labor market, either through employment or people who are on temporary lay off. And 66 percent of those employed are employed full-time.

I might add, Senator, that that number would change considerably if we had not seen another factor occur and that is the number of individuals receiving AFDC who have earned income. In some counties, over 50 percent of the case load, and many times the connection with the public assistance program is Medicaid. In fact, the Medicaid program and part of this hodge podge of services in trying to deal with this problem is providing health care benefits for many small employers, particularly in the rural parts of the State and the tourist parts of the State.

In house status, we found that people without insurance were 62 percent more likely to have fair or poor health than their counterparts with insurance. We also found that 80 percent of the uninsured in Michigan had a high school education or better which would give them a competitive advantage when you compare that to the average population on public assistance, which is about 50 percent.

In summary, we have found that an increasing problem. We have found a problem that is over presented by young people, by individuals who are native American, Black or Hispanic, by individuals who are employed and many times full-time employment. It is also a problem that we think is going to get much worse as we look down the road at the change of our economy and I suspect every other State in the nation can say that.

In addition to doing policy research, we have been actively engaged in a demonstration project called the health care access project which has been established in the last year in Gennesee County, which is the county which Flint, Michigan is located in a major industrial center and Marquette County, a county in the upper peninsula that is transitioned from a mining community to a service and tourism community.

Gennesee County today has 14.2 percent unemployment. That doubled the State average. And Marquette County has about 6.9 percent, which is the State average at this point.

Our goal in this project, which was funded by the Robert Wood Johnson Foundation and the Mott Foundation, as well as the provider community in State and local government was to determine whether a subsidy to private employers would increase access to health care and quality of health care, whether the provision of health care services through a subsidy would, in fact, help people who leave public assistance remain off public assistance, and whether a systematic level of care emerging a previously separate hospital problem with an ambulatory care program could result in a better delivery of services and reduce the uncollectibles in area hospitals.

We, in fact, have put into place a managed care plan that now has about 800 individuals the families of 370 employees in these two counties. The plan is paid for with the employer assuming one-third of the cost, with the individual employee assuming one-third of the cost if their income is above 100 percent of the poverty level to 200 percent, and State government assuming 66 percent for individuals below the poverty level to one-third for those between 100 and 200 percent.

We are finding, Senator, that, in fact, this program does make a difference. Small business will provide insurance if costs are reasonable. Conversely, the high costs of insurance appears to be the most important factor in these two communities in the provision of insurance. And 50 percent of the employers we contacted could not even afford the subsidized system. We found that insurance is more costly for small businesses for some of the reasons you heard today, not the least of which is Federal and State tax policy, as well as the size of groups and the efficiency of providing services.

We found that 40 percent of the employees involved had insurance from other businesses. Now I suspect that is somewhat overrepresented because of the nature of the economy in Flint, Michigan, with the auto industry. But, in fact, we found one business subsidizing another business, adding to the unfairness of the system and also adding, from an employer's point of view, but also the unfairness from the employee's point of view if they were not fortunate to have a spouse or a person in their household with coverage in a larger employer.

We are also finding the system to be cost effective. The average cost is about $150 per business or about $46 per employee for each of the third. That is buying a regulated and full range of benefits through HMOs and other capitated systems excluding dental and vision, but basically basic services including physician and pharmaceutical.

While our experience is still developing, I would like to just suggest that the answer to this solution, I think, is going to require a national answer. I do not think a State can go it alone. In fact, because of the competitive nature between States, any State trying to solve the problem, I think would quickly be in a difficult position. It has to be a multifaceted system.

I would suggest that the public issue needs to be addressed and I think the first priority has to be children. The fact that 32 percent of the uninsured are children and the fact that only 10 States have assumed responsibility under over 87 to provide services for pregnant women and children up to age one speaks to a crisis in health care and a crisis in children and a societal crisis that I do not think we can really take the risk of.

We know in Michigan that we can provide health care services to children at a cost of about 30 percent of our average Medicaid costs and it has a very cost effective approach. I also suggest that——

Senator DURENBERGER. Are you getting somewhere near the end?

Mr. BABCOCK. Yes, Senator. I am going to wrap up right now.

I suggest in the private employers that we really need a mix of incentives and a mix of mandates. But I think that we have to look seriously at some subsidation for low-income private employers as well as changing the tax policy to provide parity for incorporated businesses and non-incorporated businesses. We would like to share with this Committee our experiences as we progress over the next year in Michigan, both in the HCAP project as well as in the policy deliberations which hopefully will be in the legislature next fall.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement Mr. Babcock appears in the appendix.]

Senator DURENBERGER. Ms. Post.

STATEMENT OF BONNIE D. POST, CHAIRPERSON, MAINE SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE, AND EXECUTIVE DIRECTOR, MAINE AMBULATORY CARE COALITION, AUGUSTA, MA

Ms. POST. Thank you, Senator Durenberger.

I really have some conflicts. Having sat here for about 2½ hours, I am intrigued by all the debate and questions that have been discussed and know that those are the same types of things that we have been facing for the last year and a half. So I'm going to try not to depart too much from my prepared statement, some which I have crossed out a lot, as you can see.

Senator DURENBERGER. Well, I hope you know both your statements will be made a part of the record, together with any supplementary material that you want to add to it as well.

Ms. POST. Yes, I do.

I also want to add one thing. Clearly timing for health care is critical and it is upon us. Actually today, I expect much of what I am going to talk about is hitting the floor of the Maine legislature with, I hope, a unanimous ought to pass report.

Over 130,000 people in Maine are uninsured and countless more are under-insured. We in Maine have a large number of small businesses which find it extremely difficult to provide insurance for their employees. Governmental and bad debt and charity care shortfalls are placing heavy burdens on private insurance; not hospitals in Maine's case, but private insurance.

The Special Select Commission on Access to Health Care was established by the Maine legislature in 1987. One of the Commission's earliest recommendations that Maine adopt the SOBRA Medicaid options. It has done so, providing Medicaid coverage to pregnant women and infants up to 185 percent of the Federal poverty level, and to children, the elderly and the disabled, up to 100 percent of the Federal poverty level.

Presumptive eligibility, waiver of assets tests and continuous coverage for pregnant women were also adopted at that time. We are proud of the health care services that we have, with your assistance, been able to provide for our neediest citizens, but a great deal needs to be done.

The Commission adopted a number of guiding principles in designing the components of its proposed health care plan. One was to expand equal access to appropriate and necessary care. Another was to rely on broad-based financing sources. It felt that providers, employers, and the public sector and the consumers themselves should all share in the financing of health care. We wanted the plan to promote preventive and primary care; and that it was important to maintain a mixed system of insurance and service delivery approaches and public and private sector approaches.

The Commission's plan builds on the existing State Medicaid program by establishing a State subsidized insurance program similar to Medicaid, namely the Maine Health Program. It was felt that the comprehensive benefits of Maine's Medicaid program continue to be appropriate for this low income population and that uncovered services and out-of-pocket costs represent significant barriers to access to care for those with little disposable income.

Actually, our proposal is very similar to that that has been proposed to you by HIAA.

Building on the Medicaid program has several other advantages. It can benefit from the existing Medicaid infrastructure. It extends Medicaid-like coverage to other members of a family where others, such as infants and children, are already covered through the SOBRA expansion. And in some instances, it helps reduce the stigma that is often associated with Medicaid.

The Maine Health Program would be available to persons with incomes below 150 percent of the Federal poverty level, with a sliding scale premium based on 3 percent of gross income for persons with incomes between 100 and 150 percent of poverty. The Department of Human Services would have the ability to develop an assets test appropriate to this population, taking into consideration their unique needs. The benefit structure does include hospital costs because it was felt that it was important that the State pay for those costs rather than to shift them on to other third-party payers as is now the case.

We also felt it was very important that this program supplement existing insurance not supplant it, so it is designed to wrap around currently employer-based insurance and Medicare. It could do that in several ways. It could provide the subsidy for the enrollee's private insurance premiums when an individual's share exceeds 3 percent of gross income. It could provide coverage for benefits not covered by the employer-based plan, such as prescription drugs. It could provide coverage to dependents when the employer-based plan only is available to the employee. And it could provide a subsidy for the enrollees current co-payments and deductibles when the total cost to the enrollee exceeds 3 percent of gross income.

The Maine Health Program is a foundation of the Access Commission's report. Up to 52,000 individuals are expected to enroll in the program during its initial year.

I think my written testimony outlines some of the other areas of the Commission's report. I want to say, as any legislative process, there have been some victories and some disappointments. But at least the Maine Health Program and a grant program for community-based care has survived the legislative Committee process. In what a conservative newspaper in the State has described as "a monument to courage and compromise," it has been combined with a larger piece of legislation to enlarge private insurance's ability to do selective contracting, a proposal to fund the Medicaid hospital shortfall and to increase payments to Medicaid providers to improve access to health care.

Clearly, funding is going to be a problem, but a coalition of insurers, hospitals, physicians, consumer groups and the Maine Chamber of Commerce have made a commitment to find the funding. We obviously look with great interest at what this Congress, this Subcommittee and this Committee does in terms of expanding Medicaid options. Clearly those that are in front of you, particularly those for children up to 185 percent of the Federal poverty level would be of very great assistance to the State of Maine as it seeks to implement this program.

Thank you.

[The prepared statement of Ms. Post appears in the appendix.]

Senator DURENBERGER. Thank you.

Mr. Babcock, the Chairman of the Subcommittee who is your Senator on this Committee would appreciate it, and I would too as I look at the question, if you can elaborate in writing with your statement which I have not read all of, but he wants to know the adequacy of the Medicaid program in terms of how many people are covered. I think is the issue that we all bothered with that it is just too restrictive. I think you have already addressed that in part in your comments. And how would you improve the Medicaid program, itself.

And then, in particular, for all of us, in any more detail that you would like in the Robert Wood Johnson projects you talk about, give us a little more detail on what were the positive ways in which you could get small business to respond and which ones did you find were a problem.

That is going to lead me to another question which has to do with things we ought to be doing at this level to make it easier, I suppose, for small businesses to response. You might just add that.

Mr. BABCOCK. I would be glad to.

Senator DURENBERGER. Where in terms of payroll taxes, where in terms of taxes generally, or other things we may have some control over, might there be opportunities for us at this level to make your job of small business participation easier.

Senator DURENBERGER. And, Ms. Post, the Chair's question of you deals with provider participation. Do you have any difficulties getting providers do you anticipate any difficulty getting providers to cooperate in this particular system? You might just give us an observation on that. We are talking about legislation that is not yet passed, right, is that it?

Ms. POST. Unless they move very quickly today.

Senator DURENBERGER. Right.

How did you deal with that particular issue?

Ms. POST. Well, again, in Maine we had two groups who were working at the same time one was the Access Commission and one was an informal group of a variety of providers. This proposal, as it is currently outlined, or outlined in my written testimony is supported by the Maine Medical Association, the Maine Hospital Association, and clearly provider participation was one of the issues that was very thoroughly discussed.

We have included a million dollars more for providers under the Medicaid program and this will automatically up the payments under the Maine Health Program because they are based on Medicaid payments to providers. We anticipate that most of that money will go to physicians to adopt a relative value scale for primary care.

Senator DURENBERGER. Oh, okay.

Mr. Babcock, you are here representing, or on behalf of the National Governor's Association, right?

Mr. BABCOCK. Actually, I wasn't aware I do not think I am, Senator.

Senator DURENBERGER. Oh.

Well, maybe you would ask them to I do not see the usual staff sitting back there unless I am missing something. I was struck by the fact that in Maine there are 130,000 uninsured; in Michigan that 88 percent of the people are insured. I made a note to do some research myself that maybe you can do for us in this Committee. That is, those of us where you see the most activity at the State level to mandate some kind of employer-based health insurance is along the northern tier. That is not just because we are better folks than the folks down in the south. I wonder if it is not due to some other facts which also reflect a fairly high rate of current insurance coverage.

You have older business; you have larger businesses; you have much more unionization, both in and outside public and the private sector, which leads me to a concern about the south. As an example, in a whole lot of southern States where these percentages might be a lot higher, and where just imposing or mandating coverage is going to be perceived at least as being a lot more expensive. All of that seems to argue that if we wait to have this all happen on a State-by-State basis, we may get it across the northern part of the United States, but we are not going to get it in one very large region of our country.

What is your general reaction?

Mr. BABCOCK. I think you are correct, Senator. I do not know all the reasons that the northern tier We are getting involved here. I think you have identified some. Another is that our regions generally have provided a full range of services in the past and that has chipped away over the years because of pressures on State government and the Federal government in cost containment.

I can tell you I was in Oklahoma recently where the Governor's office reported an uninsurance rate of 26 percent, apparently the highest in the nation, with a much different economy, an agricultural economy. Although I suspect that there may be other compensating ways of providing care. Some States have public hospitals, as you are aware, and that in our region at least we do not have.

I think that we have to have a national policy. I think that we have seen in the last 10 years in the Midwest that we have a national economy, and certainly an international economy, and our businesses are competing with other States that do not have this level of care. But there is also the equity question across the country.

The 30 percent of Michigan of the uninsured that are children have the same needs as perhaps the 30 percent in Texas or Oklahoma. I think if we do it on a State-by-State basis we will have a very uneven and a very haphazard way of delivering services and we will miss some opportunity to also start to restructure the health care delivery system in this country that has been spoken about this morning.

We have a very inefficient and a very expensive and a very inefficient way to deliver services. We know that by experience in many States, by providing managed care systems, we can include access and actually reduce cost in many ways. I think it argues strongly for national policy.

Senator DURENBERGER. Ms. Post.

Ms. POST. I would just like to respond to that, if I could. I wanted to clarify one issue. That is, in the Maine proposal we are not suggesting mandated employer-provided insurance, and although Maine is a northern tier State, it is very sparsely unionized. It is made up primarily of small businesses. I do think, however, though, that the issue of the difference between providing access through our health insurance mechanisms versus a service delivery mechanism is an important one. We need both.

We need both health insurance and we need to support the service delivery system in order to insure access to all of our citizens. In Maine we have tended to use primarily insurance mechanisms. We have a very comprehensive Medicaid program. We have no State-run hospitals. We do not have County Health Departments.

So we have done very little in supporting the service delivery system in terms of primary care.

So it is a mix, I think. We, in Maine, for whatever reason, and maybe it is true in a lot of the other Northern States, have intended to go with insurance mechanisms primarily.

Senator **Durenberger**. But also said that there is a necessity to have both.

Ms. Post.

Senator **Durenberger**. And before that, I think in your testimony, you acknowledged what all of us know and that is the degree the growing degree of shifts in costs from these public systems to private systems.

I do not know what you are doing in Maine. I just speak to Minnesota. You know, Minnesota is paying like 52 percent of charges right now in their Medicaid system their medical assistance system. In a lot of parts of our State, particularly in the rural area, the providers are getting paid substantially less than their costs. And in one way or another, as you point out, that gets shifted where you can shift it other than in rural areas that gets shifted on to somebody else.

I wonder, you know, what is it what miracle happens that everybody pays the providers exactly what they are supposed to get paid without having it all go through one system or the other.

Ms. **Post**. We have some shifting in terms of our hospital costs, as we have an all payers system. So all of our government shortfalls those government shortfalls are primarily due to TEFRA limits as far as Medicaid is concerned all of government shortfalls and bad debt and charity care gets passed on to other major third party payers.

We have been underpaying our physicians for the past 5 to 7 years. There is recognition in the State that that has taken place and steps have been, and are going to be taken, to correct that because it is beginning to cause problems in terms of access.

Senator **Durenberger**. The last question I had was just sort of by way of clarification. If you know, one of the things that has always concerned me about relying on the health insurance system without some change in it is that most companies are going to charge you about the same rate it seems. I mean, they seem to average everything out, whether you are in the cities or you are out in the country or whatever it is.

I would dare say that if you went to some small town in one of your States, the premiums would be at least equal to what they are in the cities, or maybe in some cases they might be more. But what you do not see out in our small communities is the kinds of employers that can carry part of those premiums. We do not have our big employers, unless it is a big paper or logging company up in Maine or something like that. They are not out in the rural parts of our States.

And so such a greater percentage of the uninsured will find in rural areas a much smaller percentage of access to these heavily subsidized insurance programs. That is also out in the rural areas. So that it is very, very difficult I mean, people used to say, you know, the doctors can get by for half and the hospitals can get by for half. But now we are coming to educate all of ourselves to know that the costs are about the same in rural areas as they are in the cities, once you take out some of the cross-subsidies.

So I do not know how at the State level you all intend to deal with that, or whether you have thought about it in some way and can give us some suggestion.

Mr. BABCOCK. I was surprised, Senator, in our survey that we did not find a geographic difference. I had expected we would, particularly given the tourism and the agricultural nature of out-State Michigan.

But I think that clearly the policy has to, one, define what a minimum level of services are, as we have spoken to before; and I think there has to be reasonable rate-setting processes through State insurance bureaus, through the regulatory issue.

It may be that given the economic mix in rural parts of Michigan or Minnesota or other States that the degree of subsidy may be higher. We found that in Marquette County. But that size of sample was too small to draw any judgments from. That is a transitional economy and that may work its way out.

Senator DURENBERGER. Okay.

Ms. POST. We did two things. One is that we proposed subsidizing the individual according to income, up to 150 percent of the poverty level, no matter where they may be whether they are working for a unionized company or a larger company and getting paid a low wage or whether they are self-employed in a farm in Washington County.

The other piece was to provide specific assistance to small businesses and that was a disappointment of our legislative process. We proposed a subsidy for health insurance that was offered by business of less than 10 employees but it did not make it through the process. It seems as though, from my perspective, that once the small business community decided that we were not going to impose mandates on them, they lost interest in the process.

So they were not there as advocates for what we felt is an important piece of the package. The Chamber, representing a larger group preferred the money to go into hospital shortfall. Both the private and the nonprofit insurance companies, again from my perspective, seemed a bit concerned that the other might get a little bit of market edge out of the proposal. So that proposal is back to the drawing board and the Access Commission will be making a recommendation to legislature in January.

Senator DURENBERGER. Okay.

Thank you for patience and for your contributions. This hearing is adjourned.

[Whereupon, the hearing was adjourned at 1:27 p.m.]

HEALTH CARE FOR THE UNINSURED

WEDNESDAY, JUNE 28, 1989

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Southfield, MI.

The hearing was convened, pursuant to notice, at 10:12 a.m., at the St. John's Armenian Church, Cultural Hall, 22001 Northwestern Highway, Southfield, MI, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: David Krawitz, administrative assistant, Debbie Chang, health policy legislative assistant.

[The press release announcing the hearing follows:]

[Press Release No. H-40, June 23, 1989]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON THE UNINSURED

WASHINGTON, DC—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Subcommittee on Health for Families and the Uninsured, announced Friday the Subcommittee will hold a field hearing in Michigan on proposals to provide universal access to health care.

The hearing is scheduled for 10 a.m. on Wednesday, June 28, 1989 at the St. Johns Armenian Church, Cultural Hall, 22001 Northwestern Highway, Southfield, Michigan.

"Millions of people throughout the United States. and close to one million in Michigan, do not have health insurance," Senator Riegle said.

"I am holding this hearing in Michigan to solicit comments and concerns from Michigan citizens on the pressing problems surrounding health care for the uninsured and on policies that are necessary to effectively address these problems," said Riegle.

"One of my priorities as Chairman of the Subcommittee on Families and the Uninsured is to see that quality, affordable health care is available to all Americans," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. Let me call this hearing to order and welcome all of you this morning. We are very pleased to have this tremendous citizen turnout that I see in this magnificent room. I want to thank the church for its kindness in opening up its facilities today so that we could conduct this very important public hearing.

This is a formal hearing of the Subcommittee on Health for Families and the Uninsured of the Senate Finance Committee, so the stenographer that you see up front is making an official committee record. All statements that are made today by our witnesses and all statements that others in the audience want to give us in writing or through voice tape today, or in a very short period of time after today will become part of that official committee record.

I stress that at the outset, because while this will be a very important meeting in this room for those of us who are here to share this information and insight, the information that we gain in this field hearing today will be amplified and sent out all across the country, to all the Members of Congress and to all of the interested people who are trying to solve the health care coverage problem in America.

Each thought expressed here today will be heard by many other audiences, so it is very important that those of you that have important stories to tell, suggestions to make, ideas that you want to put forward, take the occasion today to get some writing materials from our staff members that are at this table up against the wall and write down anything you feel you want to have made part of today's official hearing record. This is an opportunity for the public to speak and to be heard, and it is very important that everyone here take advantage of that opportunity if there is something you want to share with us.

The purpose of our hearing this morning is to deal with one of the very most difficult problems facing our country and one that we must solve, and that is, as we meet here today there are some 37 million Americans, some in this room, who have absolutely no health insurance coverage at all. Each day as they awaken they face the prospect that, if they have an illness, or an illness or an accident occurs, to themselves or to their loved ones or to their children, they just have no health insurance in place to help meet those kinds of urgent medical needs, oftentimes emergency needs.

Of that 37 million Americans with no health insurance at all, 12 million are children. You will see and hear about some of those children, America's children, our children, today in this hearing. Clearly, they are among the most vulnerable people in our society, and we have 12 million who have not one penny of health insurance today to protect them or afford them the chance to be healthy, and to develop themselves and hopefully live full and productive lives later on as adults.

We have a major problem in our own State of Michigan. We are a progressive state. We care about each other. We have seen many examples of social action and progress in our State, but we have an enormous shortfall and problem in the area of uninsured persons. That is true all across America, but it is very much true here in the State of Michigan.

The best estimates that we have are that, in our State population of just over 9 million people, we have some 1 million people—some 1 million people in our State of Michigan alone—who have no health insurance. Of that total, over 300,000 are children, right here in our own State.

We have a larger proportion of unemployed adults without health insurance and uninsured persons below the poverty level, when you compare that with the nation as a whole.

Today we have some very important witnesses who have been asked to testify and will help lay out the dimensions of this problem and what we should consider doing to fix the problem. That is really the purpose here, to both identify the nature of the problem and then look in a very serious way as to how we commit ourselves to fixing it, fixing it once and for all, so that we put a health insurance system in place in America that covers every single person. That is my goal, and it is the goal and the purpose of this hearing. I think it is one of the most important goals that we have for our country as a whole. [Applause.]

Today you are going to be hearing from some individuals in very difficult circumstances who have no health insurance, and they are going to tell us what they are coping with and what they are finding. That is a critical part of the insight today.

You will be hearing from representatives from business—small business, large business—from health care providers, and you will be hearing about some unique projects that are being tested here in Michigan to try to figure out ways in which we get health insurance to the people who now do not have it.

As I say, we want to solicit and incorporate the ideas and the testimony of anyone today who wants to provide a statement to us.

This is not a new interest of mine—I first introduced a bill on the uninsured people back in December of 1982. So we have been fighting now for nearly a decade, introducing bills in each of the last four Congresses, to try to get in place a national response to the problem of the lack of health care for some of our people.

We held a hearing on this very subject recently in Washington, which I also put together as we have today. In that hearing at the Washington level we explored a variety of proposals for providing universal access to health insurance for all Americans. We are continuing that work in the form of a bipartisan coalition of active people in the Senate, including Senator Kennedy and other Senators, who feel, as I do and as I think everyone in this room does, that we have got to work out a plan that we actually enact and put into place, so that we don't just study the problem, we don't just talk about the problem, but we do something concrete to solve the problem.

Just by way of a little more background at the outset—and it is very important to set the stage for the range of testimony that you will be hearing.

In studying the problem we find that people who lack health insurance span all ages, all kinds of employment situations, and all income levels. That is a surprise to many. Most people think this is just a problem of what we think of as "poor people." While it clearly is a problem for low-income people, it is a widespread problem across our society.

In fact, when you look at the data today, most of the people, both the parents and the children, in families that lack health insurance are families where people are working and are employed. But these people get no health insurance at their job site, or, if they do, they may only get it for the worker—the mother or the father—but not for any other members of the family.

So, in fact, most of the uninsured in this country are not people who are outside the work force and living on, say, public assistance. Most of the people are working every day but in fact are not getting health insurance at the workplace or making enough money to be able to buy private health insurance. After a person pays for food and clothing and shelter, and the basic necessities to just get along, many, many working people in this country find they cannot afford to buy the very high-priced private insurance coverage.

So, the data shows us that this is a very widespread problem. We find that fully two-thirds of the people who have no health insurance are employed individuals or their dependent family members. I have charts up here that illustrate that. I am not going to take the time right now to go through that.

We have already, of course, a large public program which we call Medicaid, that is designed to provide health services for certain categories of low-income people, principally single women with children. But, for example, a single man or woman, no matter how poor or how sick, simply does not qualify for Medicaid as it is now structured within our system. So, if you really look at even the Medicaid coverage which is there for the poorest of the poor, only 40 percent—only 40 percent—of poor people are getting even that coverage under Medicaid.

Now, a lot of people don't understand that, because the welfare system is very complicated. But the fact is, even in the area where the country has acted to try to respond to that problem, we are just scratching the surface and not by any means getting at the full scope of the problem.

Some very bizarre things have happened because of the nature of the imperfections in our health care system. There is a kind of cost-shifting going on. Those companies and entities that provide health insurance for their employees are finding that the rates are going through the roof, because they are being burdened not just with the health costs that are associated with their employees, but they are now covering what are called "uncompensated care costs" from other users of health care services who don't have health insurance. Those bills have to be paid by somebody, so they tend to get loaded back into the rates of the employers that actually do provide health insurance.

So, we are finding that the failure to really respond to the problems of people who lack health insurance is, in a perverse way, driving up the costs higher and higher for those companies and for those situations where in fact health insurance is present and is available.

Hospitals are finding now that they are being asked to provide uncompensated care to sick people who come in the door. They should do it, and they have to do it, and, good Lord, as a humane nation we want to see it done. We don't want to see anybody turned away that has a health care need, but those costs then, in turn, have to be paid. If they are not paid, these hospitals build up higher and higher debts, and what are we seeing? We are beginning to see some hospitals, especially in some of the most important areas of our society, starting to shut down. They are literally beginning to close, because they don't have the money available to cover the health care services that they are being asked to provide.

If we had an insurance system in place that covered everybody, then we could solve that problem, and those hospitals could get back on their feet. They would remain open, and they would be available in areas of highest need, which are very often in our inner-city and in our rural areas. And those are the areas where our hospitals tend to be under the greatest amount of financial stress.

I will just conclude by saying this: We all know, in this room, that the nature of our economy has changed; we are now part of a global economy. In Michigan, we have seen that with imported cars and trucks coming from foreign countries now for years, and years, and years. The nature of the international economy is such that the United States is today in a very tough, competitive race with every other country around the world. If we are going to be successful in that kind of international competition, we not only have to work hard and be smart about what we do, but we have to have healthy people—we have to have healthy people. We have to make sure our people get the health care that they need throughout their lives, from prenatal times right up through their childhood and up into their adult years.

We have got to make sure, of course, that people have the education and training skills as well. But if somebody isn't feeling well, if somebody has a health problem that we can fix and we don't fix it, then they are not going to be able to produce for themselves or to produce for this country.

So, America has to think as a team. Just like the Pistons did in this recent, very impressive play-off series, we have to understand that America as a whole is a team. We have got to make sure that every player on the team—which means every man, woman, and child in this country—is well and able and healthy as much as we can help them to be so that they are able to perform, and they are able to have good lives, full lives, and are able to contribute and produce to the society as a whole. It is just that basic, and it is that fundamental.

So, it is good economics, and it is also a moral imperative to see to it that the people of our society get the health care they need all the way along the line.

There are just no two ways about it. The people who say it isn't necessary are almost always people who have health insurance themselves. So, it isn't as if they don't want it for themselves—they want it for themselves—they just aren't too excited about seeing to it that everybody else has it. But we have to think in terms of having a solution here that applies to everybody, and we are not going to stop until we get that job done.

This hearing record today will be a very important part of pushing this legislation forward. I think we can get health insurance legislation established that will provide some method of health insurance that will cover everybody. There are different ideas as to how to do it. I think our minds should be open as to the best way until we fully discuss all of the different choices and the different options, and then take from those ideas, some of which will be expressed here today, the best set of ideas we can. Then we will put that package forward and try to enact that, to get the job done for us.

With that as an opening statement, I now want to go to our witnesses. I want to say how much I appreciate all of them participating today. It is difficult to come and be a witness at a hearing, especially for the individuals who are here who have been experiencing serious health problems. They can tell us in a first-hand way what they have had to deal with and what they are dealing with each day just to try to keep body and soul alive. And to try to care for loved ones in their family circle without having the resources they need to do it the way it should be done in a modern nation like ours in 1989.

So I am going to start by calling on our individual witnesses who are here, who will provide some very powerful examples of what is actually going on. I know there are a lot of other people in the audience today who also have serious health problems within their own immediate family circles.

We have asked three different families to come and share their stories with us today, and they have agreed to do so. What I want to do now is to call on them.

The first witnesses today are Arlene and David Dilloway from Emily City. We appreciate their willingness to come to this hearing. They are going to discuss the difficulty they have had in obtaining health insurance for Arlene who has diabetes.

This is a very typical case of what is going on. It is hard to talk about, and it is hard to hear part of it, because it is a very sad situation that is going on in the lives of millions of people who are all around us. So I am very grateful for the fact that they are here today and are going to share their story with us.

David, are you going to go ahead and deliver the statement?

Mr. Dilloway. Yes, I will.

STATEMENT OF ARLENE AND DAVID DILLOWAY, IMLAY CITY, MI

Mr. Dilloway. I appreciate very much the opportunity to be here today and to share with you what our problems are.

My name is David Dilloway. I am here with my wife Arlene. She has been a diabetic for the past 15 years, and for the last 6 years she has been on insulin.

In the previous years, at times, we have had medical insurance—through the union, when I worked union; and at times when we were not working and I was unemployed, through the social services—however, at the present time I am entitled to no benefits whatsoever. This is because I work for a small company which has three employees. My employer cannot afford to stay in business and provide us with health insurance.

Many of Arlene's problems started back in 1984, when she got a small piece of wire in her foot. The doctors misdiagnosed the problem, and she lost two toes on her left foot, which makes it difficult for her to get around now.

As a result of this, we did get a small legal settlement from the insurance companies and the doctors because of this misdiagnosis.

At this point, I attempted—knowing the value of insurance—to buy insurance when I had the money. I couldn't get it. No one would sell it to us.

Senator Riegle. They wouldn't sell it to you?

Mr. Dilloway. They would not sell us insurance because of preexisting diabetes. This was, at this point, just diabetes; nothing else.

In January of 1988, on the night of the Super Bowl—I know this is when it started, because that is a good time to remember, I guess—she developed severe stomach pains and cramps. So I called our family doctor. He agree, because we had no insurance, to have us come up to the office, and he would examine her and see what was wrong. He examined her and, since there was nothing life-threatening, he gave her a shot of Demerol to calm her down and to control the pain, and he said, "Well, come back tomorrow, and we will start working on it."

This continued for the next 7 months. Throughout the next 7 months they ran tests at the various hospitals. All the time she was continually on pain-killing narcotics. I was very afraid she was going to become hooked on and not be able to get off them once the problem was solved.

But for about 3 months, through our local doctor and the local hospital, the Lapeer County Hospital, they ran various tests to try to determine what was wrong. Unable to determine this, they referred her to a horror story in the University of Michigan. It took 3 weeks before she could even get an appointment to see a doctor, and then, the doctor, on the first visit, found that there were traces of blood in her stool, so she ordered a colonoscopy the next day, which was run and proved negative. Then she said, "Well, let's try—maybe it is an ulcer." So she gave her ulcer drugs to take. "Come back in 3 weeks." She went back in 3 weeks. This wasn't it. "Come back in 3 weeks," again. For a total of 12 weeks they kept her coming back.

All the time she was on pain-killing drugs, because her family doctor, could do nothing but control the pain? While the U of M, "3 weeks", "3 weeks", "3 weeks."

After about 3 months of this, finally the pains indicated that it was her gall bladder. They ran a test to check her gall bladder at Lapeer County Hospital, and they found this was her problem. U of M referred her to a surgeon at this time, knowing that we had no insurance and no money. They referred her to a surgeon—"3 weeks." He ordered, "Well, let's run a test to see if it is an ulcer." They ran this test; it was negative. So he said, "Okay, we will take her gall bladder out. It needs to come out now." And scheduled the surgery.

Three days before the surgery was scheduled, the University of Michigan administration office called us and said we would need a $5,000 down payment or they would not admit her. I did not have the $5,000. They did not admit her.

Not knowing what else to do, I returned to our local family doctor at the Knollwood Clinic in Imlay City. He, in turn, referred her to a surgeon at Lapeer County Hospital. He, in turn, ordered her in for more tests—the pre-op tests, the same ones that had just been run at the University of Michigan. Upon getting the results from these tests, he determined that Lapeer County Hospital was inadequate to handle her, due to her high blood pressure, high blood sugar, she was anemic, among other things, they said they could not treat her safely; she needed a major medical center—where we had already been turned away.

What will I do now? What can I do?

Two or 3 days later her pains became so severe that I had to find a hospital someplace that would admit her.

Fortunately, I found Flint Hurley Hospital, where they admitted her through the emergency room. Once again, they had to run these tests—again, because it had to be done in their hospital. So, this was the third time these same tests had been run. Three times, three bills.

Three days after admitting, they removed her gall bladder. This, we hoped, would take care of her problem. Her gall bladder was bad. Her doctor said, when he examined her, "What has this woman been through? My heart goes out to her. Don't worry about the bill; we will take care of her."

From this time on, Arlene's health problems became more and more serious, and we were continuing to spend more and more money on doctors and hospital bills. I needed help from someone, so I decided, "Well, that is what the social services is for." So, I went to them.

I filled out the application. They reviewed it and said, "The assets that you have for your business and your income is too high; you don't qualify. We cannot help you." This was one reason. The other reason that she could be covered is if she was totally disabled for 12 months. The gall bladder does not disqualify you for 12 months; you are not totally disabled. So, there was no assistance available.

At this point I was left holding the bills for well over $8,000.

I really feel that the rest of our problems started because they allowed her to get so sick before she could be treated. The only way I could get her treated was through emergency care. If she had been treated earlier, I think the rest of her problems would not now be happening.

In December of 1988 her eyesight began to fail drastically. We took her to Lapeer Eye Clinic in Lapeer, where the doctor examined her and told us she needed immediate emergency medical treatment to try and save her sight. He administered what they call "laser treatments" that day, which cost in excess of $600 per treatment. He gave her two or three treatments in December and January, at which time he said he was no longer capable of handling her and referred her to the Kresge Eye Institute here in Detroit.

Upon their examinations, they determined that she had a detached retina which would need surgery. She was admitted in February for the surgery, which, at best, will save her enough eyesight so that she can see to walk around. She can no longer read or drive a car.

Also, at this time it was discovered that her kidney functions were failing. But, due to lack of insurance, the doctor said, "Well, we will just treat it on an outpatient basis wherever you can." So, she was released from the local hospital here, and 3 days later, due to nausea and vomiting and stomach pain, she was admitted to Mercy Hospital in Port Huron for 6 days. Since then, she has been in the hospital twice for extended periods, and into the E.R. room four times for emergency treatment.

I have spent many hours and many days driving her to doctors and hospitals, and, as a result, we can no longer pay our bills. I am very near to losing my home because I can't pay my house payments. Whenever we come down here, it is a 120-mile round trip. It is an all-day trip, and this is getting very expensive.

In February her kidney functions were at approximately 85 percent; they are now down to 15 percent. We have been told that she will be on dialysis, most likely, by September. At this time, she needs the tubes for the dialysis placed in her arm. Here, again, the doctor states, "I must to be paid on the day of the visit." I don't have that money. What am I going to do? How can I get this preparatory surgery to keep my wife alive? What am I to do? If the social services don't help, I have no idea.

As I have stated, most of the doctors are very compassionate. They say, "Well, we will take care of her. Don't worry about the bill." As of today, I have two subpoenas from this very doctor who had said, "My heart goes out to her." So did his hand. I don't blame him; he needs to be paid. But I can't pay him.

I am trying through various organizations to obtain help for my wife. The Red Cross has been of very limited help; they have provided her with some medications and some of the testing. This is very much appreciated.

I have called the United Way, the Kidney Foundation, the Diabetic Association, and the Lions Club. None of them will help. "There are no funds available." They all collect funds, what are they doing with them?

I went to the Social Security Administration. She is disabled, and obviously she can't work they said. She hasn't worked in 5 of the last 10 years, so she does not qualify on her own. Here, again, I am working. My income disqualifies us. We either have to be poverty-stricken, or there is no help.

[The prepared statement of Mr. Dilloway appears in the appendix.]

Senator RIEGLE. You mentioned to me, just along that line, when we spoke beforehand that if you were to divorce your wife, which of course you wouldn't do and shouldn't do—you love your wife—she could receive help that is not available to her as long as the two of you are married. And you are struggling to hold your job at the same time that you are helping her to find care for these very urgent medical problems. So it is almost as if there is a conspiracy in place to prevent the right action from happening.

If your wife's kidneys actually do fail, then there is a measure of help available. But the logical way to do it would be to make the help available ahead of time so the kidneys would have a chance not to fail.

Mr. DILLOWAY. Yes, this is what bothers me. Why should I have to divorce my wife? This is what our case worker at the social services told us: "If you divorce her, then she would be eligible," because my income and my assets would not count against her.

Why should I have to divorce the woman I love to save her life? Why should I have to go through this?

Senator RIEGLE. Well, this is precisely what the country as a whole needs to hear and understand, because, while this is what is happening in your life right now, David and Arlene, situation like this are going on in tens of thousands of lives like yours. We will hear from some others here shortly.

But I think what you have told us illustrates exactly how system is not working properly today. You are trying to work, you are trying to take care of your family situation, trying to help your wife through these very difficult problems; and yet, we have not put in place in our society a sensible way for us to be able to help each other through these kinds of situations—and sooner or later they strike most of us. It is not as if most people walk through life with no problems of any sort, because they tend to come at one time or another. They happen to be very present in your life now.

But, putting these facts on the record, just as powerfully and as graphically as you just have done, is the way that we force change. There is no other way.

I want to take your story and the others that we will hear -- I want to try to bring those to the attention of the President and all of the Members of the Congress, because we can change this, and I want to change it in time to help Arlene. That is our goal with this hearing.

Mr. DILLOWAY. Thank you, sir. I appreciate that, and I hope you hurry.

Senator RIEGLE. Arlene, we want to thank you, too, for being here. I know this is very difficult. [Applause.]

Let me go to our next witness here. We have other stories like this that you need to hear and that need to be part of this record.

Cheryl Eichler, who is going to be our next witness, is a heroic person. She has literally left the hospital today to come to this hearing and testify. That takes tremendous effort on her part and tremendous strength that she may not even have in order to do this, but it is very important that you hear her story and the kind of situation that she represents.

Let me give you just a few facts about her before she tells you the rest of it:

Cheryl works. She earns $12,000 a year. She works at a 7-11 store, but her employer does not offer any health care. She has Crohn's disease, which is a very difficult problem, and because she lacked health insurance, she was in a situation where treatment was delayed for a year, just as Arlene also found that her treatment was delayed for a period of time. In Cheryl's case, it was because she had no insurance.

When she quit her job, she still did not qualify for Medicaid, because as a single woman with no children she does not fit one of the categories under Medicaid. Agin, again, I think a lot of people think that Medicaid is out there to help people like this; in fact, it helps fewer than half of our people who are caught in this kind of situation.

It is likely that her hospital bills, which of course are mounting, would be treated as uncompensated care by the hospital, but then there is the question of how long that hospital or any hospital can continue to provide services that no one is able to pay for, and that is the other side of why this situation has to be remedied.

Cheryl, I am very proud of you for being here today. We would like to hear from you, now.

STATEMENT OF CHERYL EICHLER, WOODHAVEN, MI

Ms. EICHLER. My name is Cheryl Eichler. I am 28 years old, and I have had Crohn's disease for the past 12 years.

I was first diagnosed as having Crohn's in 1976. I was 16 years old at the time. I went to the hospital in Florida because I was experiencing a lot of pain in my side and lower abdomen. I was having dizziness, fainting, and tired very easily. The doctors told me I was anemic, and after many tests diagnosed Crohn's.

My family then moved back to Michigan in March of 1977. I was admitted to Wayne County General with the same symptoms. I had my first surgery when they found it necessary to remove part of my colon. I was in the hospital a total of 3 months. Luckily, my mother was receiving assistance through the Aid to Dependent Children Program, and because of this Medicaid we were able to survive my first battle with Crohn's.

I didn't have any problems until the middle of 1982. I had graduated from high school and found work at Manpower Services. Although I had no benefits, I was able to support myself. But soon I was in constant pain. My stomach had swollen so much that I couldn't even wear clothes very well. I waited until the pain was so bad, about 6 months, before I went for any treatment, because I didn't have any health insurance, and I didn't know how I was going to pay for the medical services.

I was finally admitted to the hospital when an abscess began draining into my stomach. I couldn't eat or drink anything for about 8 months. The drainage never stopped, so in August of 1983 they took out more of my colon and performed an ileostomy. I was able to apply and receive Medicaid to help cover the costs of the treatment. Unfortunately, Medicaid only solved the immediate problem, and when I had recovered so that I could return to work, I was again without any type of medical insurance.

I found a job at 7-11 and was again able to meet my daily living expenses. Eventually I was offered a salaried position and earned about $12,000 a year. In October of 1985 I was again suffering the effects of Crohn's. I waited about 2 weeks because I didn't have any insurance. I was dehydrated and anemic.

In September of 1986 I developed peri-rectal abscesses. They are extremely painful and produce a great deal of drainage; but, again, I didn't seek treatment until the end of 19897 or the beginning of 1988, because I was very scared, had no insurance, and didn't know how I was going to pay for it.

Finally, in March of 1988 I had outpatient surgery for drainage of the abscesses. I set up a payment plan for this bill and am still making payments for this surgery. I also have the added expenses for the care of equipment of my ileostomy and the doctors I was seeing every 2 weeks, and the additional expense of prescriptions.

On May 15 of this year I was forced to resign my position at 7-11 in order to be admitted into the Westland Medical Center. I was losing weight, very run down, had a lot of pain, and the abscesses were draining heavily. I am still in the hospital.

When I had my first surgery in 1977, my bill for 1 month of care was about $20,000. Now, after 1 month, my bill is over $34,000. Twelve years ago I had my mother's Medicaid to help pay for the bill; today I have nothing. I applied for Hill-Burton Funds from Westland Medical Center, but I was rejected because my $12,000 a year income was too great to qualify. I have applied for Medicaid as well, but have been told that I do not meet the definition of disabled. They told me that they would review the case further, but it would take an additional 45–60 days to reach a decision.

In the meantime, I am ready to be released, but only if I can continue on my present I–V treatment for the next 3 months. But, without the promise that Medicaid will help pay for this treatment, the suppliers will not provide the equipment. One bag of hyperal for the I–V costs over $100, and since I have been at Westland I have used over 70 bags.

Eventually I will need more surgery to remove the rest of my colon. Without this surgery, there is a good risk that I would develop cancer. Until I get some kind of aid, I will have to remain an inpatient at the hospital.

Even if, by some miracle, I am granted Medicaid for this latest bill, that only solves the immediate problem. They don't know what causes Crohn's disease, therefore there are no cures. There are many people in my situation, and, for us, this is a life-long illness.

Ahead of me lies the frightening task of finding another employer who will be sympathetic to my disease. Even if I'm lucky enough to find something, I'll be unable to find a job that will provide coverage for my treatment. Those of us with Crohn's could never work enough or make enough to pay for the long-term care that is involved with this disease. There is also the constant worry and emotional stress of "How am I going to pay for these bills?"

The treatment involved in battling this disease is extremely expensive. Someone like me who earns about $12,000 a year could never afford to pay for this. I think there is a definite need for help to the uninsured people in situations such as this.

[The prepared statement of Ms. Eichler appears in the appendix.]

Senator RIEGLE. Cheryl, I think what you have just told us is about as powerful a story as most of us will ever hear, in terms of the difficulties that life can present us with and the tremendous courage and strength that you have shown and are showing.

I feel so strongly about it. I think if our country can't find a way to help people like you, there is something radically wrong with the way we do things. We talk about patriotism—there is a big controversy now about burning the flag, and a lot of other things yet we have got individuals like you and Arlene, who are what America is all about that need help right this minute. And it doesn't seem like there are very many people who want to help, or are at least willing to do the things necessary to see that help is there.

We are spending billions on what we call "defense." But we don't seem to be able to find any money to provide some defense for you against the Crohn's disease. We are building nuclear warheads. They cost millions and millions of dollars apiece. We have almost 13,000 nuclear warheads right now and are building more every day. We dare not even use them because, if we do, everybody in effect would be killed.

And yet, here you are at 28 years struggling with this problem, and you are our country. Were we investing in you?

The purpose of this hearing is to figure out how we change this, and we want to change it in time to help you, and to help Arlene, and others that we are going to hear from today. [Applause.]

This is an aside, but I want to say it. It is interesting that many of us, as we are young, are taken by our families to religious services—church, synagogue, whatever. In most religions we learn about helping each other and helping people, caring about other people, doing unto others as we would have others do unto us, and we talk about that. It is all woven through our founding documents as a nation—you know, the idea of "one for all, and all for one," and a nation caring about all of its people. You wonder how it is we could get so far off the track in a modern society with all the things we see—all the things on television, the big rush for the Rolex watches and all the things, the status symbols and everything else—when we have our own flesh and blood, as a nation, in these kinds of situations desperate for help.

And we can afford to help, as a nation. It is not as if we don't have the capacity or the resources to help our people. And it is a terrific investment. It is the right thing to do, but it is also the smart thing to do, because we want our people to be well and to be healthy. We want Cheryl to be able to work. She wants to work. But the notion of a young person, a single young person, in this country having to be afraid to go and get the health care they need because they know they can't pay the bill is a terrible, terrible indictment of our system today and the indifference that has been built into too many of our attitudes.

I must say, I think we have seen too many examples in recent years of leaders, even at the very top of our government, who just don't want to see, or can't see, or won't see problems like this.

I think it is our job as a society to see these problems and do something about them—not next year or 5 years from now, or after a lot of the people that needed the help aren't here anymore. I really think we have to have the kind of citizen commitment to get this done, along with those of us in public office who can push this thing along, to insist that changes be made—to insist on it. To insist on it. And if the money has to be taken from other things, then let us take it from other things, and let us spend it where it is needed. [Applause.]

Let me go, finally, to our last witness here who is going to talk about the situation that she finds herself in.

Carole Renaud is here with her two 6-year-old twins who have Downs Syndrome and who do not have health insurance. The children do not, although the rest of the family does, and the twins are actually excluded because of their condition.

When you think about it, you sort of say to yourself, "Why would we ever do it that way? I mean, if you have got somebody in the family unit that you know needs help, isn't that where we should aim the help?"

Instead, what we have is a system where the person in the family who needs the help is told that they can't have it. They can't have it because they need it. And because we know they need it, and it is going to be expensive, we don't want to give it to them. So, Arlene can't get care for her diabetes; Cheryl can't get help for the Crohn's disease; and Carole is unable to get the kind of help that these wonderful little twin boys are needing, because they need the help. They need it, and therefore they can't have it. That's how upside down this thing has become. It is just outrageous that that is the case, and it has to be changed.

Carole, you are very kind to come today and to bring your little tykes with you. I would appreciate it if you would tell us all your story.

STATEMENT OF CAROLE RENAUD, WARREN, MI

Ms. RENAUD. Thank you for having me here.

My name is Carole Renaud, and I am a mother of four children. I am here to testify today on the problems that my family has been having in getting health insurance for my two 6-year-old boys.

In 1985, we were on general assistance. My husband Gary was going to a career training school. He had previously been through a machining training program, but he could not find a job that paid enough money, so we were on assistance for a while.

During that time he ended up looking for another job and could not find one, so we applied for assistance, something we did not want to do, but we had to. We made more money on assistance, because not only did we receive a monthly check, we were entitled to receive food stamps and Medicaid, and at that time we needed the Medicaid. At this point the health insurance was important, because I was pregnant and needed medical care.

During the year we were on general assistance, Gary went back to school to get his high school diploma. He really wanted to learn, and he was convinced that if he received additional training, we could get off of welfare. He really hated being dependent on assistance. That is when he decided to enroll in a trucking school. To help pay for this training, Gary got a grant and a student loan, and his parents helped with the down payment. It really paid off, because when he finished the program the school helped place him in his position that he is in right now. The first company that he went to had hired him, and this same company put him on a training program for 2 years. It was like an apprenticeship program, to further his education and his job.

When he first got the job, he contacted the Department of Social Services to notify them of his earnings. The Department of Social Services informed him that they would take this information and eventually wean us off the program.

For a while we received a monthly check, food stamps, and Medicaid. This assistance, however, became smaller and smaller as each month passed. For our family the Medicaid was especially important because we had four children, including our two twins here with Downs Syndrome, and kids often get sick and need medical assistance. We knew, without insurance, we would have serious problems.

We began to look for health insurance about 6 months after we were completely weaned off DSS assistance. We were receiving no checks, no food stamps, and no Medicaid. We were in a difficult situation because, as a trainee, Gary's take-home pay was about the same as we were getting on assistance at that time, and that is not including the health insurance. He had no insurance. He wasn't entitled to any medical benefits, and there was no way we could afford to pay for it ourselves. I encouraged Gary to ask his boss for some help, and, when he did, his boss told him that he would be happy to pay for our insurance. He really thought Gary was a good worker, and he didn't want Gary to leave to look elsewhere for a job, somewhere else.

A few weeks later I received the health insurance information and the forms to complete. When I was filling out the forms, I came across a question regarding whether we had anyone in the family with Downs Syndrome. I thought to myself, does this really make a difference? I answered the question, hoping that it wouldn't.

In addition, I had to tell them that Matt and Joe had been hospitalized for pneumonia. Joe and Matt became sick because the house that we were living in at the time we were on assistance had no heat throughout the whole winter. We couldn't afford to move out of the house yet. Gary had gotten his job, and we were trying to get out. We were trying to save the money to get out of the house. They had caught colds while we were there, and it developed into pneumonia.

Later, when we moved out of the house, the city had put a sticker on the home. I believe if we had not lived in that house, Joe and Matt wouldn't have gotten pneumonia.

I think it was a month later when we heard from the insurance company, after we had moved out of this house and had applied for our insurance. It was like a month later, after we applied, that they explained they would cover Gary, my two other children, and me, but not the twins. I remember feeling very upset. I cried when I received the letter, and Gary looked very sad. My husband doesn't become emotional when he is sad; he gets very quiet. So, I knew he was very upset. We both didn't think this sort of thing could happen. How could an insurance company refuse to entitle two children, just because they were born with a handicap?

In addition to feeling mistreated, I was also very worried. Matt and Joe, the twins, they tend to trip and fall a lot because they are uncoordinated. Once, when Matt was very young and wobbly, he lost his balance and fell, and he broke out one of his front teeth. If it had been more serious, we would have been in big financial problems.

A year later we tried again to find health insurance for the twins. This time we went to my husband's boss, who said he would try to help. He contacted the insurance company and was told that we could obtain insurance for Matt and Joe; however, we would have to pay the premium for the entire time that the rest of our family members were covered. Gary's boss was not willing to pay the entire year of premiums, and we knew that we could not pay them, either. Gary, who was still a trainee, wasn't making enough money. We were just trying to save so we could get out of the house that we were living in, and, like I said before, the house was a disaster, and we really needed to get out of there.

We weren't going to give up. We continued our search for health insurance. Gary's boss also looked into changing insurance companies, or changing the policy with the present company, but those attempts failed. Then Joe got sick, and I had to take him to the doctor. His chin was swollen, and the doctor wanted to put him in the hospital. I told him I could not afford it, so he put him on a strong antibiotic. He also told me to check with the Association for Retarded Citizens. He said that ARC intervenes on behalf of people with Downs Syndrome and their families.

In addition, his receptionist typed a letter which indicated that Joe and Matt did not have any major medical expenses, and they were in fact healthy boys, and they had no major medical problems. The doctor told me that I should show this letter to the health insurance company so they would know that the kids were healthy. I took this, sent it to them, and they sent me a letter back. After a few weeks I received a reply. They thanked me for the letter, and they told me they were sorry, but they were still unable to insure the twins due to their guidelines.

My next attempt was through ARC. ARC knew that the insurance company was using outdated guidelines, which have a significant impact on the eligibility requirements. So they sent the insurance company updated information on Downs Syndrome people. We were hoping that this new information, coupled with the statement from the doctor, would educate them so that they would change their decision. We were, however, once again turned down.

My husband's boss decided to make one last attempt to help. Again, he contacted the insurance company on our behalf. This time he told us that the twins were red-flagged. When someone is red-flagged, that means they will never receive health insurance coverage. I don't know if the twins were red-flagged because I contacted them so many times, but I did know that they would not insure my twins. That was the last time we heard from the insurance company and assistance from my husband's boss.

Joe was sick a week ago, and we still haven't obtained insurance. Again, my doctor was upset and told me to call the ACLU. The ACLU told us they couldn't help and told me to contact Senator Riegle's office. Senator Riegle is the Chairman of the Subcommittee on Health for Families and the Uninsured, and I thought he might be able to help me. That is when I decided to call, and that is how I became involved with this hearing.

Before I finish I do want to make a statement: When Matt and Joe were born with Downs Syndrome, the doctor told us that we could give them up. If we did, they would be taken care of by the State, and they would have health insurance. But we loved them, and we wanted to be responsible for raising them. My husband got good employment so that he would be able to take care of his family and provide a good home for us and health insurance, and take care of us on his own. Now he found out that he is unable to obtain insurance for his sons.

We go day to day in hopes that nothing serious happens to them, because we wouldn't be able to pay for their health care. It is ironic that the State says that I can give them up and they will take care of them; but when we say we will love them and take care of them on our own, it is our responsibility—they won't help us. There should be some kind of insurance that protects us. It just doesn't seem fair, because I love my kids. [Applause.]

[The prepared statement of Mrs. Renaud appears in the appendix.]

Senator **Riegle**. Well, that is a very powerful story that you share with us, and it moves all of us. We love your kids, too.

As I said earlier, I think, we have to make ourselves remember that all of the children in this country are America's children. They are our children, and we don't want any children red-flagged, or red-lined, or red-anything; we want our kids in this country to be included, not excluded. [Applause.]

We need to get the word out, out to everybody within the sound of the voices of all of us, that every industrialized country, every single one on the face of the earth—with the exception of South Africa, but every other modern country—provides health insurance for people like you have just heard from. Every other country manages to do it, although by and large their incomes are a good bit less than ours. How is it, in a modern age, that other societies can look in the mirror and realize that we owe something to each other and to the common good, and that we provide that kind of protection for people? Those countries have acted to reach out and help the people that need the help. Our country is doing just the reverse.

We are saying, in effect, that the people who are out there who need the help the most are the ones that we are, in effect, determined not to help.

So, the children who need the special care, under our system today, in many cases are getting a red flag put on their name so that they don't get any care. Well, that is not right.

I will just say this to you: I don't think a President of the United States—I don't care who he is, where he comes from, what party—should serve a day in office without showing some awareness and willingness to respond to that problem in our society. [Applause.]

We need help from the top, and not just there. We need it as well from the Congress. We need it from our leaders across our society. We need it out of the private sector. We need it from our citizenry.

You know, if the citizens of this country will say in a loud enough voice that we want something done about this, we insist that something be done about this, do you know what will happen? Something will be done. Something will be done.

This isn't China, you know. This isn't a situation where we can't speak out or we can't have an effect on what happens in this nation. We can have an effect, and it becomes very important, not just that hearings like this take place that really frame the issue and really give this thing a major push, but every single person has an obligation to act as a leader.

Every person in America has an obligation to act as a leader; that is what democracy is about. It is not about the other person, it is about yourself. And if this is something that you feel strongly about, then it is something that you should act on, just as I am attempting to act on it, because I need your help, and they need your help.

Tens of thousands of people across this State who are not in this room today, and whose stories are not being told, who are struggling with precisely these kinds of problems, they need your help.

So we need some activism. Just the people in this room making a major effort, and all the circles of influence and access that you have, can make a real difference. So I urge you to think about the personal responsibility side of it, because when these folks that you have just heard from walk out of the room, they are not going to walk out of our lives or out of the lives of America; their problems go on each hour of each day, and they are counting on us to help them.

I want to be able to say to them right now that we are going to help them, that we are all going to help them. [Applause.]

I want them to understand that there is that kind of commitment in this room. They need to know that. They need it just to be able to get up and cope with another day.

So, before finishing and excusing those witnesses, you are certainly welcome to stay if you wish. I know you may not be able to, and I know, particularly, Cheryl, you may have to leave soon, but I want you to understand that the effort you have made in coming today, and in building this hearing record, and in putting these personal stories on the record, as difficult as they are to tell, is a very important service to the country, because what you are talking about is a problem that is not only your problem, but it is far, far greater. So you have been very courageous in coming today, because you are here for so many, many other people, and you are giving those people a voice who otherwise wouldn't have a voice.

So, in my mind, you are true heroes for both coping with the situation you find yourself in and for coming here today and standing up and saying what needs to be said. If we needed to find a group of American heroes to pay some homage to, in my view, we could start right with this table right here. [Applause.]

Now we are going to look at another aspect of this problem. We are going to be shifting now to a second panel. We have two important witnesses who are going to give us some summary observations and comments as to aspects of this problem that they see from their special vantage points.

We have Mr. David Benfer, who is the Executive Vice President of the Henry Ford Hospital in Detroit; and we have Dr. Boucree, who is the Medical Director of the Hamilton Family Health Center in Flint.

So, we have two individuals who are representing organizations that are seeing first-hand each day the health care needs of the whole cross-section of our society—one in a large medical facility, the other one in a much smaller-scale facility, so they can really give us a blend of insight that is important for us to know as we work on crafting the best kind of solution here.

Mr. Benfer, let us hear first from you.

STATEMENT OF DAVID W. BENFER, EXECUTIVE VICE PRESIDENT, HENRY FORD HOSPITAL, DETROIT, MI

Mr. **Benfer**. Thank you, Senator.

I am David Benfer, executive vice president of Henry Ford Hospital and group vice president of the Henry Ford Health Care Corp. Today I am accompanied by Darlene Burgess, our vice president for government affairs.

I would like to thank you for taking the time to investigate the issue of access to health care for the uninsured.

Senator, we just heard several very moving stories which detailed the human suffering that results from no health insurance. It is stories such as this that I have experienced that have developed my view that health insurance is a basic right for all American citizens.

Health care for the uninsured is a growing concern in Southeastern Michigan. Overall, more than one million people in Michigan are without some form of health insurance coverage. Forty-nine percent of that uninsured population are thought to be in Southeastern Michigan, and estimates place the number as high as 350,000 of them in Wayne County. Thus, the percentage of people without insurance in the Henry Ford Hospital primary service area may be as high as 20 percent. In addition, a substantial number of these people who live in Wayne County are also recipients of Medicaid.

One way to measure the level of need is to look at the amount of uncompensated care hospitals currently provide and what the trends are.

At Henry Ford Hospital, we currently finance $14 million per year for uncompensated care and will absorb an additional $16 million in Medicaid underpayments this year, 1989. This financial burden has grown more than 40 percent over the past 3 years, and I would like to call your attention to attachment 1 in my testimony. Such cost are not unusual for similarly situated hospitals located in Michigan central city areas. For example, Southeastern Michigan hospitals saw their uncompensated care, exclusive of Medicaid underpayments, grow from $140 million in 1985 to $196 million in 1987.

Care for the poor has traditionally been available at community hospitals. This care was supported by a technique known as Robin Hood financing, or cost-shifting. That is, hospitals, including Henry Ford Hospital, have been able to keep their doors open to people unable to pay for their services by shifting the costs for providing free care to other patients of the hospital.

What has changed to make cost-shifting less tenable in today's world? Basically, two things.

Senator RIEGLE. Can I just stop you right there? You are making such an important point, and, if I may, I want to just make sure everybody in the audience understands what you have just said, because as we try to put this whole picture together, this is one of the critical facts.

You talked about cost-shifting and when you have somebody come in with an urgent health need who has no health insurance, you can't in conscience turn them away—and you won't, because they are desperately in need of help. So you provide the help, even though you know they can't pay the bill. That bill has to be paid, or, otherwise, the hospital just keeps running up a bigger debt, and eventually the hospital has to shut down because it has no other source of money, itself.

So, what you in effect do with this cost-shifting is that you have to end up in a sense adding to the bills of those patients that you have who are covered by insurance and whose bills will be paid. It is not that you do it to be devious, or anything of the sort, but it is the natural way in which the hospital keeps its doors open. If it is serving a certain number of people who can't pay and have no insurance, and meeting those needs, somehow that cost has to be absorbed; so that then spills over on top of the so-called "paying customers," and the charges that they have then are larger, just in order to keep the hospital running.

So you have this very bizarre twist occurring, that companies or individuals that are providing insurance for people who come in and who can pay the bills are finding that their rates are going higher and higher through no fault of theirs or really any fault of yours, but rather, because there are these other costs over here that have to be covered somehow, and in the absence of any kind of a broad insurance scheme that covers everybody, we haven't found any other way to do it. So, that distortion is building up in the system which travels under the name of "cost-shifting."

I will just make one other point about it, and then I want to go right back to your testimony, and that is, you can only cost-shift so long. And especially if the hospital or the medical facility is absorbing more and more of the cost of services it is giving that nobody is paying for, and it keeps building up a bigger and bigger debt, we all know what means: eventually it is just not going to work. The hospital will be in trouble and may actually have to close. So, that is not a strategy that makes sense, nor even is that a strategy that works indefinitely.

Is that a fair statement?

Mr. **Benfer**. Senator, you are right on target. That is a very accurate statement, and that is traditionally how uncompensated care has been provided for throughout the health system.

Returning to my testimony and picking up on your comments, basically two things have made cost-shifting less tenable in today's world:

First, the cost-containment efforts of large purchasers, including the large employers and the Federal and State governments, have reduced our ability to cost-shift.

Second, the total cost for uncompensated care has grown dramatically as a result of the increasing number of people who cannot afford to pay for care, as well as the overall cost increase associated with high technology in the health industry and the growth in the aged population.

Traditionally, cost-shifting financing for uncompensated care works, when large payers such as Blue Cross or commercial insurers or the self-insured employer are willing to subsidize these programs. But overall cost-containment strategies generally translate into fixed pricing arrangements that minimize the large payor, including the State and county governments, exposure to cost-shifting.

In the June 19 issue of "Crain's Detroit Business," local business executives identified containing business health care costs as a top priority. With fixed pricing growing as a cost-containment strategy, the margin that has traditionally existed to pay for charity care, and to offset Medicaid underpayments, is rapidly disappearing.

Henry Ford Hospital's present payor mix is indicative of the cost-based to fixed-price reimbursement trend. Today, more than 80 percent of our business is fixed price. Six years ago that number was less than 15 percent.

I am not here to defend the old cost-shifting system; it was expensive and inadequate. But our data indicates that a large percentage of unsponsored patients are delaying care until emergency conditions occur. We track the payor mix of our emergency department, and the numbers reveal that about 20 percent of the services provided in the emergency department are for unsponsored patients, compared to less than 10 percent of the patients admitted to the hospital. A simple extrapolation would suggest that thousands of people in Michigan have limited access to care and delay care until it results in an emergency room encounter.

The current system is not working. More dollars are required just to stay even with the existing programs for the needy—the very young, the very old, and the very poor. Critical indicators such as infant mortality place parts of Michigan at the bottom of the list. Millions of people don't get basic care because they can't pay for it and don't have insurance. In addition, the pool of individuals entering the work force will shrink during the next decade, requiring greater attention by employers to the health care needs of their workers. The question is, where do we, as a society, look for solutions?

In today's system, those who pay for health care act as the voice of the patient. Under this system, there are 37 million uninsured Americans who have no voice. We believe the Congress has to be the voice for those citizens.

The Henry Ford Health Care Corporation, along with many hospitals, have specifically expressed support for Senator Kennedy's Employer Mandate approach. From our perspective, any plan that (1) eliminates financial barriers to basic health care, and (2) assures that providers, hospitals and physicians, are not competitively disadvantaged because many of their patients can't pay for care is acceptable. Senator Kennedy's bill is a big step in this direction for low-income people who have jobs. From my perspective, Medicaid expansion and better Medicaid funding is also overdue.

Our mission as an organization is to try to continue to serve in the best way we can. We have no intention of backing away from the people of the city of Detroit and people without the ability to pay. The Federal Government currently helps in this regard.

Henry Ford Hospital carries one of the largest loads of people who can't pay for care in the entire State. We also, as part of our mission, train over 470 medical interns and residents—these are physicians in training—as well as 160 nursing students and 35 allied health students. Many of the professionals trained at Henry Ford stay in Michigan, and a large percentage remain to practice in the center city. Those who stay in Detroit often will serve to train others to follow them.

The Medicare program recognizes health manpower needs and service to low-income people by providing targeted support to strengthen institutions that contribute in this regard. In 1988, Medicare adjustments to Henry Ford Hospital for education and care to low-income people constituted about $30 million. These payments are directly related to our ability to finance care for the uninsured.

Stated in another way, any reductions in Medicare payments for Direct and Indirect Medical Education costs or Disproportionate

Share payments—that is a disproportionate share of indigents—would directly add to the current $30 million we now finance for unsponsored patients at Henry Ford Hospital. We are concerned about the current discussions in Congress about reducing Medicare hospital payments, which will erode the present Federal effort to support uncompensated care costs.

The Medicare program provides Henry Ford Hospital with supplemental payments in recognition of our role in this community as a source of care for low-income people and a major training institution for health care professionals. We respectfully urge that such efforts be maintained as you search for long-term solutions.

To summarize, new linkage between the private sector and the government are needed to ensure adequate, cost-effective health care for everyone. Government, employers, private payers, and health providers have to work together to achieve broad-based solutions.

This past year the Henry Ford Health Corporation recognized this issue which, Senator, you have outlined so well, and we organized an Urban Health Initiative which brings together urban health care providers, the county and city health departments, the Chamber of Commerce, the Medical Society, Blue Cross, the Health Council, and a representative from your office, to develop a strategy to respond to the growing needs of uninsured Americans in Southeastern Michigan. We don't have a local solution yet, but we are designing a strategy that reflects the Senator's team approach through a broad-based coalition which is necessary to solve these issues.

Senator, I pledge my support to your efforts.

[The prepared statement of Mr. Benfer appears in the appendix.]

Senator RIEGLE. Thank you very much. That is an excellent statement. [Applause.]

I want to thank, too, the Henry Ford Hospital and, in thanking you, all of the health providers in our State, for the commitment that all of you make under very difficult circumstances of the kind that you describe today. But this is very helpful testimony, and we will make full use of it.

I want to make a couple of announcements. We have 425 people in attendance today, and I think that is really a stunning fact by itself, when you think of the fact that this is a normal work day and is in the middle of the morning. It is a very wonderful location, and we are very grateful to have this location today, but it is not an easy spot necessarily to find. [Laughter.]

We were not able to give maps out, so I am especially grateful that, in the web of the freeways around here, all of you were able to find your way in. But I want to say to the St. John's Armenian Church, in the Cultural Hall, this very grand room which we are in, that we are very grateful to them for opening up their facility.

I also want to introduce the people on either side of me, who are so instrumental in our work to craft this new national answer to this problem.

I want to introduce David Krawitz here, who is my administrative assistant, who works with me in Washington and is really an outstanding expert on health issues and human service issues generally. David has been very key over the years in the advances that we have been able to make in catastrophic health insurance coverage and a lot of other things.

Seated on my other side here is Debbie Chang, who has done really an exceptional job in helping us to structure the new work of our Health Subcommittee in the Senate Finance Committee into really focusing in, as this hearing is doing today, on how we move this thing forward so we actually get a new answer developed and in place.

So, I want to thank both of them and to have you meet them, so that you know the part that they play.

Let me now go to Dr. Boucree. It is very important that we say in introducing you, Doctor, representing the Hamilton Family Health Center in Flint, that the statistics I have show that uninsured people in our society comprise somewhere between 30 percent and 50 percent of the normal patient load, for example, that you would receive as a typical community health center across Michigan. So that, on a smaller scale than say the Henry Ford Hospital, you would be seeing a very large number of uninsured people who come to you often in desperation for their health care needs.

So, you will be speaking from that perspective, and we would like to hear your statement now.

STATEMENT OF DR. MICHAEL BOUCREE, MEDICAL DIRECTOR, HAMILTON FAMILY HEALTH CENTER, FLINT, MI

Dr. BOUCREE. Exactly, Senator.

On a day-to-day basis, 30 to 50 percent of my patient load numbering approximately 20 to 30 per day, would be uninsured, with no health care at all. The other 45 percent, perhaps, would be Medicaid, which is an underfunding as we are finding today; the other 5 percent being Medicare, Blue Cross/Blue Shield, in which case, as we have discovered, and we have persons who are employed who may have Blue Cross/Blue Shield benefits, however do not make enough to pay for a simple $20 office call. So, therefore, I consider them to be uninsured also. When we are talking about hospital care, that is something totally different; but I am talking about ambulatory care.

I think I feel beckoned to make one disclaimer, however: I am not representing the American Medical Association, but I am speaking on a greater part for the National Association of Community Health Centers, as I am a member of a Community Health Center, and I am a member of the National Health Service Corps, both of which are national or Federal efforts to combat the issue of health care for those with under-insurance and uninsurance in America.

However, as stated in my testimony, I am seeing ever-increasing evidence daily that there is a lack of concern for the indigent in America, further substantiated by President Bush's "kinder and gentler America," including the National Health Service Corps, the Community Health Centers, Migrant Health Centers, Medicaid program, Maternal and Child Health Block Grant, the WIC Program, and immunization programs, in the "black box" to reduce if not completely defund the institutions or programs in order to meet the national debt.

Community health centers have as their mission the delivery of comprehensive primary care services to the medically underserved, regardless of race, color, creed, sex, or the ability to pay. And according to the Michigan Primary Care Association, you already discussed that approximately 30 to 50 percent of our clientele are uninsured.

Who are these persons? They are the seasonal and migrant farm workers, they are Hispanics, Asians, Whites, Blacks, Indo-Chinese, American Indians, and Haitian refugees—the melting pot of America. Interestingly, however, they do not all fit the stereotypical uninsured person which might be thought of. And health care for the poor has been cited as "fragmented, episodic, crisis-oriented, and underfunded," as we have seen in all three testimonies previously by our patients.

Who comes to us? They are young, school-going teens in need of care for clinical problems, as simple as strep throat and sexually-transmitted diseases to serious problems as sickle-cell disease and diabetic coma. They are those who seek sanctuary at a facility where concern, compassion, and interest in their medical, dental, and mental health problems, and the treatment of those problems, regardless of third-party payor, is the rule and never the exception.

Since 1965, when Neighborhood Health Centers were established, these persons and hosts of others have sought health care at our centers; but, with radical changes in funding status and reimbursement, these facilities face a tragic demise, with the result being the loss of access to health care for many people who, for obvious reasons, could not afford to go elsewhere.

When we talk about primary care services, we are talking about someone to deliver those services, in the form of a physician, or a nurse practitioner, or a physician assistant; the availability of diagnostic services, in terms of a laboratory and x-ray; provision of emergency medical services, preventive health services, education, and counseling.

If we look at these, looking at it through five points, five critical elements of primary care, I think we will have a bird's eye view of what we need to do to combat the problem under uninsured health care: the problem of accessibility, comprehensiveness, coordination, continuity, and accountability.

It is through these fundamental elements that I will bring you into the world of the uninsured, my world of the uninsured.

Reports document that:

One in six Blacks and one in four Hispanics are completely uninsured, compared to one in 11 Whites;

50 percent of these persons are likely to need physician services, and 90 percent of these are likely to need hospital care, but not receive it;

An estimated 37 million Americans do not have any form of insurance;

One million Americans are denied health care because they cannot afford to pay for it, and an additional 14 million do not even seek the health care because they know they can't afford it;

Homelessness is an ever-increasing population in America, and many are not even eligible for governmental or State entitlement programs, primarily because they need a fixed address; these persons do not even know where to go for health care, much less determine how they will pay for health care, therefore they stay away from the health care system altogether, and a recent report by the CDC says they may be harbingers of infectious diseases such as tuberculosis;

Persons who are infected by the Human Immuno-Deficiency Virus have no provider to turn to, because of fear of rejection, a fear of poor quality care, and abandonment, not only because of their diagnosis but because of their inability to pay, thus increasing their morbidity and hastening their premature death;

There are disproportionate high infant mortality rates for Black mothers, as opposed to White mothers, because of a lack of accessibility to a health care system; and

There are untreated substance abuse problems, because these persons cannot act as a system to have someone refer them to counseling agencies for guidance and treatment.

Through enhanced funding availability, existing community health centers would be able to advertise their ability to serve the population at large and acknowledge their expertise in diagnosing, treating, and managing primary care illnesses. However, because of our increased demand and our low supply of physicians to combat this problem, we are unable to completely advertise our services because of the need-demand ratio.

For those persons who do access our services, we put them on a sliding fee scale based on their income, and those who cannot afford to pay work out some arrangement so that we do not have to, as the first testimony said, subpoena someone for costs. What our interest is, what my interest is, is to get the problem treated. I, as a minority of physicians, feel that we need to correct the problem, and what you have in your pocket I, personally, really could care less about. However I would like to speak on behalf of my colleagues, I know that I am in the minority.

After a person has entered the system, there is a whole new world which exists. Should a problem be too difficult for the primary care physicians to handle, as Mr. Dilloway quite frankly outlined, I must refer the patient to the hospital or a greater source to handle this problem.

Health care providers and community health centers, through the support and facilitation of their administrators, are likely to have established linkages with local community agencies and hospitals to provide services beyond the scope of primary care intervention. As such, the patient with chest pains who has sought care at the community health center can have the benefit of a cardiologist's evaluation, if needed, and/or non-invasive or invasive diagnostic cardiology procedures to determine the cause of the patient's chest pains. This is usually performed at the discounted rate or a charitable fee to the patient.

However, due to the unfortunate malpractice issue beleaguering Michigan's physicians and physicians nationwide, they are reluctant to see any patient without insurance because of the reported litigious nature of uninsured clients and the risk of their practice becoming known as "the poverty doctor practice," and the loss of income resulting from treating a number of uninsured clients without subsidy.

To compound the issue, public hospitals are facing rapid closures because private hospitals are not willing to accept charity cases, and therefore the uninsured cases are all shipped to the public hospitals. Local and Federal agencies are drastically reducing funding to the public institutions, in attempts to make them more self-sufficient.

Yet, while this maturity has developed clinically, the economic climate has stifled further growth and placed limits on their expenditures, while mandating they meet the demands of the public need on a shoe-string budget. Further, agencies may not be able to accept patients into their substance-rehabilitation programs because of their uninsured status.

These issues therefore provide secondary barriers for access to true comprehensive care.

Community health centers are usually able to provide the access to these services by virtue of informal and formal non-monetary agreements with private practitioners, hospitals, and agencies to provide for these needs.

Once the client accesses the system, there is a more fundamental issue that we need to deal with, other than treating the immediate problem—that is, health promotion and disease-prevention activities, health maintenance activities, and someone that the patient can say, "This is my family doctor," and not have any fear of retribution because they cannot pay.

It is unfortunate that many persons who are uninsured see the emergency room as their primary place for consultative medical needs because of either the lack of a physician to coordinate their care or the lack of a physician to provide care on a continuous basis.

Forty percent of all health center visits are for preventive and health-maintenance care, and a greater percentage of health center patients receive physical exams.

The responsibility for performance, delivery, coordination, and follow-up of these activities generally fall to the physician, as he or she is "the attorney for the poor," as the scientist Virchow put it. However, in a community health center, there is a very high patient-to-provider ratio, as I have already outlined, approximately 30 patients per day to one of me—12,000 per year to myself, the general practitioner, and the nurse practitioner who work in the community health center. And that is only 12,000. There are approximately 15,000 persons in our county and in our surrounding area who have an unmet need.

By virtue of the administrative and clinical support structure, nurse clinicians, social workers and, in rare cases, case managers coordinate the care for the patient, under the guidance of the primary care physician, and facilitate a smooth and healthy continuance through the life cycle for the patient.

The final element embodies several different aspects, intangible to the primary care patient but very important: quality of care assessment, reimbursement, and mission-objective satisfaction.

Health centers have achieved a very high level of satisfaction among the patients they serve. One study sowed that center users rated centers higher by 2 to 1 than any other major source of health care, including private physicians, because of their quality, comprehensiveness, attentiveness, and convenience. Those interviewed said that they would choose health care centers even if others provided care free of charge.

As a non-profit organization, by definition we are not interested in making a profit. However, we are mandated by the Federal Government to collect and reduce our dependency on Federal funding. However, whether we want to or not, our dependency is being reduced because of the reduction in Federal and State dollars; yet, with this reduction there is a concomitant rise in demand for our services. Therefore, the groundwork for the controversy over care for the uninsured increases, and the dilemma in effecting the balance between advertising for service delivery and capability for service delivery is set.

In summary, "the poor and such should be given some care, because to give such care reflects the best ideals of how we want our physicians, citizens, and society to be. The highest motive for treating the sick and poor is the highest form of moral excellence." The facts presented here and the facts presented today only scratch the surface of the plight of the uninsured in their quest for health care. But through it all, our health center, Hamilton Family Health Center, like other community and migrant health centers in Michigan and across America, are able to proudly stand and recite our mission and feel comfortable that we are meeting our program and mission objectives without failure. But it is still not enough.

Unfortunately, while I am very humbled to sit before you and present this, I am very tired. I tend to be the only physician able to provide this type of care, but I feel very limited in what I can do. I feel it is not only my responsibility to provide this; I am not the only person in America who has taken the Hippocratic Oath to provide health care. Through some way, I think we need to urge my colleagues to at least accept the care of the uninsured, even though there will be a reduction in profits, with some sort of subsidies or anything that you can affect the Congress to do.

Thank you. [Applause.]

[The prepared statement of Dr. Boucree appears in the appendix.]

Senator RIEGLE. I appreciate very much your important and comprehensive statement. It really lays out this problem from the vantage point that you are so well-qualified to speak from. I also appreciate your personal commitment and what you are doing. For those 30 or so patients that come in each day, a lot of them high-risk patients, it is obvious that, if you wanted to, could take your doctoring skills, and you could go elsewhere, and you could make a lot more money with a lot less effort. Isn't that a fair statement?

Dr. BOUCREE. That is true. And I say, very humbly, when persons ask why did I go into medicine, my frank statement is, " It was never a financial motive; it was just something I wanted to do."

Senator RIEGLE. And I am proud of the fact that that is the case. We need to make sure that more people like you are able to make their way into medicine. We need to make sure that people who want to help people conquer health problems, without the major focus being centered on the economics of the business but on providing health care for people, that those people who have that motivation are able to do so.

I am interested in that question, of how we open the door maybe a little wider to people like yourself in this society that have the God-given gifts to be a doctor but may not otherwise have the chance to get the training.

Apart from the threatened budget cuts, it is one thing to talk "kinder and gentler," but it is not going to be "kinder and gentler" if we are shutting down the community health centers in the country that are treating the desperately ill among the poorest people in our society. To say it and then behave that way shows that the statement, at least in that respect, would be a fraudulent statement. We have to line up what we are doing with what we say we are doing.

I appreciate very much what both of you have said. We have had some requests from some of the members of the press who are here. They keep coming and going, as members of the audience do. Some have to leave, and they have some questions that they would like to pose and get answers to before they go.

We are going to take a brief 10-minute break here to let everybody stretch their legs for a minute, get a drink of water or go to the rest room, or whatever. We will start again in 10 minutes.

Let me announce who our next panel will be: We will be going to Mr. David McCammon, to Mr. J.W. Erwin, and to Mr. William Hoffman. These are three important witnesses.

We are about half-way through our hearing schedule this morning, so let us now adjourn the hearing for a 10-minute break, and we will reconvene at that time.

[Whereupon, at 11:52 a.m., the hearing was recessed.]

AFTER RECESS

Senator RIEGLE. Let me call the hearing back to order, and let me ask everyone to find seats if they can. I appreciate everyone's patience this morning and participation. We are covering a lot of ground here, a lot of very important ground.

I want to now introduce our next panel. I am going to introduce all three individuals, and then we will take them in order:

Mr. David McCammon, who is the vice president of finance, and treasurer, of the Ford Motor Co. He is accompanied by Mr. Jack Shelton. We are very pleased to have him.

We have Mr. J.W. Erwin, who is the owner of Erwin Farms, from Novi, who is going to give us the perspective of a small business. It is a very important part of this issue, and we are very appreciative of the fact that he is here this morning.

And finally, Mr. William Hoffman, who is the Director of the Social Security Department of the United Auto Workers. We are very pleased to have you, as well. It is a very important organization that you represent, that has been a pioneer in the area of health insurance for our citizens and certainly our workers.

So, gentlemen, we welcome you. We are very pleased to have you.

Mr. McCammon, we will start with you.

STATEMENT OF DAVID N. McCAMMON, VICE PRESIDENT, FINANCE, AND TREASURER, FORD MOTOR CO., ACCOMPANIED BY JACK SHELTON, MANAGER, EMPLOYEE INSURANCE DEPARTMENT

Mr. McCAMMON. Thank you, Senator Riegle.

My name is David McCammon. I am vice president, finance and treasurer of the Ford Motor Co., and with me is Jack Shelton, who is Manager of the Employee Insurance Department at Ford. We are here on behalf of Ford Motor Company to testify on the important problem of providing health care for the uninsured.

Ford shares your concern about the 37 million people in this country who do not have health insurance, and the tragic consequences that result from many of these individuals not receiving needed health care. Further, we are concerned about the additional 15 million individuals who do not have adequate insurance. Like you, we hope to find the solution to this serious problem which diminishes the quality of life for those involved, as we have heard today in some specific examples.

Ford, like many other major employers, is affected adversely by the uninsured and the under-insured, because providers of medical services—namely, doctors and hospitals—often shift the costs of uncompensated care in the form of higher charges on insured patients. It is important that any program you develop for the uninsured and the under-insured provide for quality of care and spending controls.

However, we would like to caution that the problem of the uninsured and under-insured is a part of a much larger national problem, the failure of the present health care system to deliver quality health care at affordable prices.

We believe the problem of the uninsured cannot be solved without dealing with the broader issue of increased health care costs. The high cost of health care not only has made it impossible for many to purchase insurance, but it is also affecting adversely the ability of U.S. businesses to compete with foreign companies in both worldwide and domestic markets.

In 1988 the U.S. health care costs were nearly $550 billion. That was about 11.5 percent of the gross national product, and about $2,180 per capita. U.S. health care costs have been increasing at double-digit rates in the last 20 years. Other countries with whom we compete in worldwide and domestic markets have health care costs significantly below the U.S. For example, in 1986, the latest year foreign data are available, U.S. health care costs per capita were 41 percent higher than Canada, 80 percent higher than Germany and France, 130 percent higher than Japan, and 170 percent higher than the United Kingdom. All of these countries provide comprehensive coverage to all of their citizens.

Ford's health care cost experience has been similar to the U.S. experience, with double-digit increases. In 1988, Ford's health care costs for automotive operations exceeded a billion dollars and are projected to double by 1994. The proposed changes in accounting standards that will require accrual of the costs for post-retirement health benefits will make these costs even higher.

Solutions to the present health system that only respond to the access problem, such as mandated employer benefits, all too often result in higher costs by creating demand for health care services without correcting the shortcomings of the supply side, such as unnecessary and inappropriate care. Once in place, government programs with inadequate controls have resulted in higher costs. For example, according to Dr. Philip Lee, Chairman of the Physician Payment Review Commission, Medicare outlays for physician services tripled between 1980 and 1988, reflecting rising utilization of services per enrollee. Further, the evidence suggests that many services delivered to patients have little or no value.

In the past, the government has attempted to solve its resulting cost problems by shifting costs to the private sector through reduced benefits, restricted eligibility, or partial payments to providers. The government's share of personal health expenditures has been reduced from 40 percent in 1985 to 38.6 percent in 1987, or nearly $6 billion. During this same period, private sector costs have increased from 60 percent to 61.4 percent, with businesses picking up one-third of the increase.

We urge that in your considerations you look at the broader issue of the need for a national health strategy that will meet the following goals:

First, assure access for the uninsured;

Second, provide high quality care; and

Third, contain costs.

A piecemeal solution may only increase costs and thus prevent more Americans from receiving needed health care. We believe all the major participants—providers of health services, purchasers of care, consumers of services, and the government—need to work together to develop such a strategy.

Mr. Chairman, in closing, we commend your interest and your initiative in this important and complex problem, and we stand ready and look forward to work with you in any way that we can be helpful. Ford wants to help find a solution as soon as possible to the problem of health care costs which has caused such hardships to millions of Americans, as we heard today in some of the extremely compelling and heart-breaking individual cases.

So, thank you very much, Senator Riegle, for the opportunity to appear before this hearing.

[The prepared statement of Mr. McCammon appears in the appendix.]

Senator Riegle. I appreciate your statement. It is a very important one to us, and I am struck by several things in it. I will just mention one:

You say that government has scaled back its reimbursements in the health care area. It has had the effect of loading more costs on to the private sector, and especially those companies like Ford that have good, comprehensive health insurance that it offers its workers and its families. And if you overlay that on top of the effects of the last tax law change, where there was a tax burden shift, where we lowered personal taxes and increased business taxes, in an offset, for companies competing internationally—as certainly Ford is, and any number of other major companies—as your costs go up, whether because of the shift in the tax burden or these medical costs being shifted over through these rather hard to trace relationships that raise your insurance rates to cover uncompensated care for others, it puts more and more of a burden on American firms that are trying to provide jobs and do well in the international economy.

I think this is another important facet about understanding not just the need to make sure that people get good health care, but the need to distribute these costs in a sensible way without harming our own economic foundation. We should not be harming the companies that produce a lot of jobs and a lot of our economic income.

We are going to hear that from the next gentleman, seated next to you, right now. In a sense, the beauty of a hearing of this kind is that we can have the Treasurer of Ford Motor Company sitting beside a gentleman who represents small business, coming at the same problem but from different vantage points. We need both perspectives. We need all of the perspectives if we are going to blend them into a situation that is going to work for everyone.

So, with that, Mr. Erwin, we would very much like to hear from you now.

STATEMENT OF J.W. ERWIN, OWNER, ERWIN FARMS, NOVI, MI

Mr. ERWIN. Good afternoon, Senator Riegle.

My name is J.W. Erwin. My son and I own and operate a fruit market in Novi by the name of Erwin Farms. Erwin farms is our family orchard and has been in operation since 1922. I opened the retail store in 1963. My brother now runs the orchard. I would like to thank you for holding a hearing in Michigan to listen to small business problems in providing health care coverage for employees.

I am here today to tell my story and also to represent the 22,500 small business owners in Michigan who are members of the National Federation of Independent Businesses. About 84 percent of NFIB's members in Michigan employ 19 or less people; 50 percent have five employees or less. Finding affordable health insurance is a major problem for us.

Our store employs 18 people, including five family members. We have a good record of employment and have not laid off any people in years. Our employees become members of our business family, and it is important that we help them in all ways possible.

Our Blue Cross/Blue Shield coverage—we do have it for four people who are on salary. This coverage has increased $50 per quarter for the last 2 years; so, each year it has increased $200 per employee.

Our coverage is through the Farm Bureau, of which I am a member and have been for many years. If I did not belong to the Farm Bureau the insurance would be even higher, due to the small size of our business. Because of the cost of health insurance, I am only providing coverage for four of my full-time employees. Without help from the Farm Bureau, we would be unable to pay for any of them.

It costs me $764 for 3 months of health insurance on one family, or about $3,,056 per year, not including expected premium increases. In computing what it would cost me to cover part-time employees, I find that for an employee who works 17 hours, insurance coverage would cost $3.16 per hour. If the employee works 20 hours a week, it costs us $2.69 per hour. The cost of this coverage for a full-time employee breaks down to $1.35 per hour. Since my part-time employees earn between $4.50 and $7.00 an hour, providing insurance would almost double my payroll costs for these employees.

Several years ago, through our local Chamber of Commerce,we were able to get less expensive group coverage. The insurance was cheaper, but the benefits were not as good, and we returned to Blue Cross/Blue Shield through the Farm Bureau. There aren't many choices for us, and most of them are too expensive.

I believe that much of the increased costs are due to doctors scheduling far more tests for patients through the fear of malpractice insured suits. These additional tests not only add to the cost of each claim, they require our employees to be away from the business for much longer periods of time in order to take these various tests.

We have one employee right now with a very serious arthritis problem. He has probably had almost a day a week off for the last year. Of course, he is being fully paid for it. I am paying for it, because he is a choice employee that I just couldn't bear losing; but he still is taking all of these tests. He has been through some of these tests six times.

In closing, I would point out that my employees receive health care coverage tax-free. I pay 100 percent of their premium costs. To me, the employee is not tax-free. Seventy percent of the cost comes out of my pocket—out of my profit margin, which isn't great to begin with. Also, as the cost increases, the employee does not see this as a pay increase; but it really is. It does not act as a reward and does not increase productivity like a regular pay increase would, and therefore it is totally inflationary. I am going to have to change this technique this year; because of Section 89, I can no longer do this as it has been done. I am going to pay their insurance coverage, but they are going to pay income tax on it. That is starting this year.

Senator RIEGLE. Let me just say, on that point, we are in the process of changing that Section 89 aspect of the tax law. And I think the change that we anticipate making will in all likelihood directly affect a business of your size, with 18 employees. So we should talk about that, so you have a sense as to what is coming. It will be a beneficial change. It will be a change that will be very helpful to you. But that is in the works, and that is going to happen. I just wanted to flag that so we can talk about it afterwards, so that you know that.

Mr. ERWIN. Very good, indeed. But getting, again, to the position where I figured I could not pay it, I had to pay a man about $500 just to get the information, because I couldn't understand the thing, and I found many more cannot understand it, either.

Senator RIEGLE. That is one of the reasons we are changing it. [Laughter.]

Better late than never. But we are going to try to fix it and make it the way it ought to be.

Mr. **Erwin**. Our retail store sells primarily perishable items. We are directly competing with big supermarkets—chains like A&P, Kroger, Farmer Jack, and so on—which are less than a mile from my place of business. We have three major chain stores within a mile of where I operate. Last year our net profit was $39,000. If insurance costs continue to rise and government continues to mandate benefits, we will reach a point where it will no longer be profitable for us to stay in business. Remember, the consumer pays all of the bills. If I have to pay more, I have got to charge more.

Thank you, sir.

Senator **Riegle**. Thank you very much, Mr. Erwin.

[Applause.]

[The prepared statement of Mr. Erwin appears in the appendix.]

Senator **Riegle**. Let me just say, in passing, that we appreciate both the job that you do on your farm and providing income and work for 18 individuals. You have been doing it since 1922 as a family, and it is not easy.

When you look at the diversity of our economic system in Michigan and across the country, it is everything from the Ford Motor Companies on the one hand to family farm operations like yours on the other hand that have really given this country the tremendous output and achievement that we have seen. And there is a way to solve this problem. The fact that every other industrial nation has figured out how to do it without killing off small business or large business ought to tell us something. If they can all find ways to do it, we ought to be find a way to do it, and I think we can.

I think in the end, when we get a sensible system in place that is balanced and has the right kinds of disciplines in it, and yet meets the health care needs, the quality health care needs, I think it will probably lift a burden off your shoulders—not just a financial burden, but an anxiety burden, a worry burden.

You have just described this one employee who has been going through the whole series of tests, and so forth and so on. The system as it is sort of designed, I think, causes a lot of that to happen; there is the question of whether it causes much too much of it to happen.

But I think if we can get an intelligent system in place that provides the kind of insurance system so that the full burden doesn't just fall on the business enterprise, and the conscientious business that wants to try to provide it doesn't find it virtually impossible to do because of the financial requirements of it, if we can have that in place, you will have one less thing to worry about. You will have enough other things to worry about—whether there is too much rain, too little rain, this, that, and the other—but that will be one problem that won't keep you awake at night worrying about it. Plus, over time you will probably have a healthier and in better shape work force as time goes on if we can do this intelligently.

That is what other countries have found. And, we are a country that is sort of a product of all of the other countries; we are basically a nation of immigrants. We ought to be able to fashion a plan here that can work and have a net benefit to you. That is what I am looking for, and I think we can get it.

If we don't get it, I think you are going to see a certain grinding down that goes on in your situation that is the small business counterpart of the kind of grinding down that Ford feels it is experiencing in a situation where it has a very comprehensive but expensive health care program.

So I think, all across the spectrum from large to small business, we can devise a plan where we all come out ahead. That is really the goal. If we keep our eye on that objective, I think we can achieve it.

I appreciate your testimony very much, and I appreciate your taking the time to be here with us today.

Now, Dr. Hoffman, we are very pleased to have you here. You are certainly a person who is well-qualified to speak on these issues, serving, as you do, as the Director of the Social Security Department of the UAW.

We would be very pleased to hear from you now.

STATEMENT OF WILLIAM S. HOFFMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTO WORKERS, DETROIT MI

Mr. **Hoffman**. Thank you, Senator. We commend you. We are indeed fortunate to have a man of your calibre representing us in Washington, and your caring leadership on issues like the one you are holding hearings on today is something that stands you apart from your colleagues, and we appreciate the opportunity to be here.

I would like to have my full text included in the record.

Senator **Riegle**. We will make it a part of the record.

Mr. **Hoffman**. I have put together a few comments that I want to make that depart from the text.

Senator **Riegle**. Please do.

Mr. **Hoffman**. We believe, and I think it is fundamental, that access to quality health care is a basic human right, and all of our activities have derived from that basic tenet.

The fact that millions of Americans, 37 to 52 million Americans, don't have access to minimal quality care is not only a national tragedy, it is a national disgrace. I say this to you: If our country located another country in the world where 37 million people did not have minimal access to basic health care, we would soon send foreign aid to that nation, and we would take care of those people. In fact, 37 million is more than the total population of the country of Canada, just a few minutes north of here, and they have a fully-comprehensive universal health care program.

The ultimate answer? Clearly, it is a national health insurance program. I submit to you that the Health Security Partnership Plan recently developed by the Committee for National Health Insurance, which is a Federal-State partnership program, should be considered very soon as the answer.

It is also folly to look at the uninsured and how we handle health care in this country. In addition to the incredible personal and social tragedy, uninsured people are forced to wait until problems are more intensive and more expensive before seeking get care. We have heard about this earlier today. Multiply this situation by thousands across the country. We provide services to the medically needy in the least efficient manner. This places great strain, not only on the urban hospitals but also the rural, sole community hospitals that are picking up the problem.

We touched a little on international competition. I have had the privilege of representing workers of both the United States and Canada for over a decade. I have also had the privilege of dealing with our brothers and sisters in the International Metal Workers Federation in Geneva, Switzerland. We visit them; they visit us. They don't understand our problem. In their country, such concerns are addressed in a more enlightened way. They wonder why we have the staff that we have dealing with such issues as health care, and I can't answer their questions.

But let me tell you a little bit about what is going on in Canada. The costs to the firms that we have dealt with over the years in Canada are approximately one-half the costs to provide comparable health care in this country. Look at the national experience in Canada since 1965. In 1965 the United States and Canada had a comparable portion of their gross national product devoted to health care, and look at how many people are covered—theirs is universal, and we have 20–25 percent without access at all. Today, we are over 11 and pushing 12 percent of gross national product, and they are not quite at 8.

So, it can be done.

Senator RIEGLE. And we are spending 50 percent more and covering far fewer people.

Mr. HOFFMAN. Absolutely.

Senator RIEGLE. I mean 50 percent more of GNP, and yet we are leaving out roughly 25 percent of our population.

Mr. HOFFMAN. Absolutely.

This hits our firms that are involved in international competition in a couple of ways. You have identified already that the uncontrolled non-system of health care quality, and costs are an increasing problem with every firm, whether they are fortunate enough to be represented by a union or not. When we go to bargaining, it is an incredible problem that we jointly face.

In Canada, the arguments are over whether or not you should have over-size lenses in your prescription eyeglass program or whether or not shampoo should be included in your prescription drug program. That is the difference between handling the major concerns such as health care in this country and being able to devote attention from good minds on both sides of the table to solve other problems. In Canada, the necessity is just taken away. In the United States we have to solve what really is our national problem at every bargaining table.

We have done some estimates based on some facts and assumptions and tried to understand what the cost-shift is for employed spouses of auto workers in the Big Three, and this does not include other dependents—these are people who are employed elsewhere but who are not covered by insurance provided by their employer—and it is roughly 15 percent. On a very conservative basis, that is at least 20 cents an hour.

When you are talking about 20 cents, it doesn't sound like a lot; but it can easily be, at General Motors, up to $120 million a year;

and I would estimate it to be about $40 million a year, give or take a little.

So, we are hit twice. Those firms that are involved in international trade, are hit by being required to pick up the costs of the uncompensated care that you talked about; and direct shifts in who provides the coverage. We have a non-system here, with escalating costs and quality concerns that go well beyond anything reasonable.

We clearly support the need for a national health insurance plan immediately in this country. We also understand that there may be some intermediate steps that will allow us to get to the ultimate goal. We are supportive of those initiatives, and we stand ready to work with you. Those initiatives that are based upon employment need to include a minimum benefit package; they need to include all workers including part-time workers, and to require significant coverage for dependents.

In addition, we need to expand Medicaid in this country; and when we do both of those together, we are coming very close to the ultimate goal of taking care of all citizens. I believe it will be only a short step from fulfilling the real needs of America, and that is a national health program.

Thank you. [Applause.]

[The prepared statement of Mr. Hoffman appears in the appendix.]

Senator RIEGLE. Thank you.

I have looked at your prepared statement, and we will make that a part of the record. I appreciate these additional comments.

I wanted you to know that the Committee for National Health Insurance testified in Washington on their proposal on June 19, at the hearing that we held there. So, we have had the chance to look at that, and that is one of the matters under review.

I can't help thinking, as we are finishing here and going to our next panel, about the story that Mr. Erwin tells about the worker who has been with him for many years, who is very productive, and is now having chronic health problems and how you are feeling about the importance of that worker and the loyalty built up over the years, that you are hanging in there with that employee while that employee is just not able to produce the way they have in the past or would if they were healthy.

Think about what can happen. Let us say a second person out of your 18-person work force got hit some other day, in an automobile accident or some situation such as that, and again it was a problem where the health need of that individual in effect reached the point where it could endanger your entire business. You would have a situation where your compassion and your work loyalty and your desire to want to help could end up putting you in a situation where you might actually see the entire business, which has been going since 1922, put in jeopardy.

I think that is going on all over the place right now with firms of your size, and many smaller. You cite the statistics of how many businesses we have that have five or fewer employees. If somebody were hit and needed health care in a situation like that, it may be even more severe.

What is the point I am getting to? I am saying I think this problem has run in the wrong direction long enough that it is now impinging on the performance of business as much as it is impinging on the health of the workers or the individuals involved. I think it is true from big business of the Ford Motor scale down to the smaller business, Mr. Erwin, of your size.

Now we have to step back from it and look at this, and we have got to say to ourselves, "Look, we need all of our businesses, large and small, functioning well." They have to produce. In fact, it is a lot tougher, because the international competition is a lot tougher. We don't want your health broken in the meantime, as you are trying to run this enterprise, because you have pressures that are beyond the capacity of the business to support it.

If we have a health care need that basically is sort of a universal kind of problem that faces the whole country, then what we need to do is be smart enough to craft a basic answer that takes every American, in one form or another, into the insurance pool. We need to spread those risks out in such a way that we can meet those needs and get those folks healthy and then back on the job so that they can perform; but not have the pressure of that situation be so extreme that it either destroys their lives or the pressures build up so that they destroy a business like yours, or, in the case of the Ford Motor Company that has a comprehensive plan, through the help and the negotiating efforts of the UAW over time, that it becomes impaired in terms of its ability to perform internationally simply because it is doing what common sense, in terms of keeping our workers well and healthy.

If we are not at a point where we can figure this thing out now, when every other industrial country in the world has figured it out, then we are not very smart. And I think we are that smart. But sometimes I think what can happen is that we get diverted. We are complacent, we don't pay enough attention, things sort of go off in their own way, and so forth, and we don't necessarily go after it to try to figure it out and reshape it and put it in a different form.

I hope that out of this hearing what is starting to accumulate is enough insight on this problem that it is clear it doesn't make any sense to leave it the way it is, that the way it is right now is working against us, and that there is a way to take it apart and put it back together in a different fashion to where it can work for us—can work for us economically and can also work for us in terms of not having people's lives just blown apart, because, if we have any element of feeling at all, we don't want to see that happen to people. We don't want it to happen to ourselves, and we don't want it to happen to people who are our fellow citizens, who we may not know but who should not have to go through that terrible kind of situation, in any case.

Gentlemen, let me thank you for your testimony. It has been a very important part of the hearing. [Applause.]

Let me now take our remaining witnesses.

I want to thank you very much for your patience. You have heard everybody else testify, and we now have you at this point where the insights you will bring really complete this picture. So this is a critical panel for us.

Let me introduce Martha Serafini, from Kalamazoo, who is the Administrator of the Good Neighbor Fund. This is project that helps people without health insurance find affordable health care.

Also, a person I have known for many years and my family has known for many years, Beverly McDonald of Lansing, who is the Executive Director of the Michigan League for Human Services. She is going to discuss two health care projects that are unique, going on right now in the State of Michigan. One happens to be in the City of Flint, a larger urban center; the other in the Upper Peninsula, in Marquette. These are two trial projects that are providing transitional care to the uninsured. They help small employers, of approximately the size of Mr. Erwin's operation, in providing health insurance to their employees.

So, we are delighted to have you.

Linda, you are accompanying?

Ms. **Lane**. I am with Ms. McDonald.

Senator **Riegle**. Very good.

Martha, would you like to make your statement now?

STATEMENT OF MARTHA SERAFINI, ADMINISTRATOR, GOOD NEIGHBOR FUND, BRONSON HOSPITAL, KALAMAZOO, MI

Ms. **Serafini**. Thank you.

Before I make my statement, I would like to say that I think, as a nation, a lot of times what happens is real vulnerable groups in our society become stereotyped, and I think that is what has happened with a large amount of our uninsured people. I think hearings like this can dispel some of those stereotypes, and they can also dispel some of the stereotypes of the institutions that try to care for these people as being "money-grabbing bureaucracies."

In my job, I work in a hospital, and I also work with the uninsured. I think both stereotypes need to be addressed before this nation can turn around their attitudes toward both groups.

The Good Neighbor Fund was founded in 1963 and has helped more than 44,000 people. Donations from patients and family members, employees, and the community are received by Bronson Health Foundation, which is part of our corporation, and deposited into a special account. The account is then used to pay for hospital bills, and medications, and different out-of-pocket kinds of expenses that families have when they have someone who is hospitalized. Eligibility is based on the individual's financial and personal situation, and usually they are referred to my office by a social worker or someone in the community, a family member, or even the patients themselves.

The Patient Relations Department then assesses the request and authorizes the assistance to the hospital business office.

Although there is an official limit on the amount of funds a recipient can gain, the Patient Relations will also take a person's hospital bill and negotiate with the business office. For example, if I give the business office $3,000 on a $10,000 account, I try to negotiate with the business office in an attempt to have them write off any remaining balance.

At times, these patients are people involved with Michigan Rehab. We have representatives from Michigan Rehab who call me and say, "Gee, I can get x-amount of dollars to pay on this woman's bill. She can't work, but she is not disabled. What can we do?" So, if I authorize a specified amount from the Good Neighbor Fund, and he authorizes a specified amount from the State, we then ask the business office write off the rest. This is our attempt to join forces and get the bill taken care of for the patient and for the hospital.

In addition to inpatient hospitalizations, an equally critical need of patients who are uninsured, are medications, and I don't think we hear enough about the importance of prescription coverage for these individuals.

There are times people have to choose whether they will buy groceries or their medications. The physician hands them a fist-full of prescriptions and feels he/she has done their job. Unfortunately, and the person has absolutely no resources to pay for the medication, so they end up going home, not taking their medicine, and coming back into the hospital with no insurance. So, all it does is exacerbate the problem, and increase the cost to both the patient and the hospital. The Good Neighbor Fund has funds available to those people upon discharge. This assistance provides a one-month supply to get them through until the Medicaid process can be initiated or other resources can be explored.

Sometimes, when you provide this type of assistance to a patient, it can see him/her through, and they don't have to have their prescriptions renewed. But, for a lot of other patients who have long-term prescription needs, it really just buys them time, without solving the real problem. These individuals go from one agency to another, like the gentleman who talked on the panel earlier. The Red Cross will help on a one-shot basis; the Good Neighbor Fund can help on a one-shot basis, and so on. Sooner or later they end up without the medications and with no resources, usually within 2 to 3 months.

Having worked with this population for a number of years, I have seen the requests for prescription and treatment assistance dramatically change. It is now at the point where, for the first time in 10 years, we have had to have two moratoriums on the amount of requests we can take. This is not because the requests aren't legitimate or people aren't eligible, it is simply because we are running out of money.

I have always looked at the Good Neighbor Fund as something that was absolutely indispensable to the lives it touches, but it really has become a band-aid on a brain hemorrhage. There is no way we can continue to fund the enormous needs of this population, especially when hospitals are being reimbursed less and less from Medicaid/Medicare, and absorb more and more of the costs themselves. With shrinking reimbursements of these groups and the dramatic increase in the number of those who are uninsured and underinsured, hospitals cannot continue to simply absorb the cost of providing care.

One of the enclosures I sent with my text tells the story of two families that were very similar to the situations these panelists dealt with. Both were employed. Both were working poor—not indigent people, not people looking for handouts, as a lot of people want to stereotype the uninsured—but working people who are doing all they can to stay out of the welfare system, yet have no resources to pay for their health care, for themselves or their families. I have been to the point, where I have been tempted to tell people, "Quit your job, and let the State take care of you, because it is the only way you are going to be able to feed your kids and take care of them when they are sick, too." These are the choices our society has given these people.

[The prepared statement of Ms. Serafini appears in the appendix.]

Senator **Riegle**. Well, I think it helps illustrate, again, how the system has gotten twisted out of shape, in such a way that the incentives and the barriers cause the wrong things to happen.

Ms. **Serafini**. Right.

Senator **Riegle**. For instance, if somebody will divorce their spouse, or somebody will quit their job, then they can get help; or, if the person in the family doesn't have a chronic problem, they can be insured. But if there is somebody in the family that really does have a serious health problem and needs the help, then under the current system, "We red-flag them and then they can't get the help."

You start to see how the system gets twisted off its purposes in such a way that it can't possibly work right.

I am concerned about something else you said. Kalamazoo is a very special community; there is a lot of public support in the community, and the people who have supported this fund over the year obviously feel strongly about it. There may have been—I don't know—some corporate help. I would guess there is, because it is a community where there has been a strong civic ethic of that kind.

But I hear you say that in all of your experience there now, of at least a decade, all of a sudden the pressures have grown to such a size, the cut-backs are so severe in terms of medical reimbursements, and even though people still want to help, you are finding that there just isn't the money available in your fund to continue to meet the needs the way it was before, that there are now people who come for help who can't get help.

Ms. **Serafini**. Right. And this is the first year that this has ever occurred. We are actually are in danger of losing all of our money. The Fund has been around since 1963, and this is the first year that we are going to run dry if we don't do something.

Senator **Riegle**. I think that also is a very important illustration about the degree to which we can count on the "thousand points of light," you know? I am all for the "thousand points of light," and there are a lot of those points of light in this room today—you are one, and there are many others who have given a lot to try to help a broad social problem—if you will. But there are limits to what can be accomplished that way.

We mustn't fool ourselves into thinking that somehow there is a magic answer out there in the private sector, with private giving, private charity, private service, that is going to be big enough and strong enough to meet this need. In a community like Kalamazoo, even with a sterling record of that kind of civic willingness to help, if you are running out of money to meet the needs, it is just one more indication that we are talking about a great, big, comprehensive problem that needs a great, big, comprehensive answer.

I think the people who run our government are going to have to "read our lips," and what our lips are going to have to be saying is, "We want health insurance for everybody in the country. We don't want it 10 years from now, we want it now, because it is needed now and because it makes good sense." [Applause.]

Beverley, we would like to hear you now, and we are very anxious to have your statement.

STATEMENT OF BEVERLEY McDONALD, EXECUTIVE DIRECTOR, MICHIGAN LEAGUE FOR HUMAN SERVICES

Ms. McDonald. My name is Beverley McDonald, and I am the Executive Director of the Michigan League for Human Services, a 77-year-old statewide organization that is citizen-based and engages in a broad range of education and advocacy activities to improve human services in Michigan. In the last 10 years, we have been very involved with and committed significant resources to health care issues, an effort which has escalated in the past few years because of the problems of the uninsured.

I would say, too, that I serve as a Director of Blue Cross/Blue Shield of Michigan representing small employers, so I have some sense of private insurance issues as well.

Before I share anything more of my prepared testimony, I think we have to recognize, in terms of a disabled person receiving Medicaid, that there was once a rational basis for the current approach, which was: If you couldn't work, you needed help; and if you could work, you were going to get insurance on the job. But we keep all kinds of people out of Medicaid who can't work—and even if they could, they wouldn't get insurance on the job, and they are disabled by anybody's definition. We certainly heard from them this morning.

Coming from a client services network, I can tell you we had all kinds of cancer patients who could work and therefore couldn't get Medicaid for necessary treatment. When then could no longer work, then they were declared "disabled," and then they could get Medicaid for their treatment—but it was too late for the treatment. So, I think of you want examples, there are dozens of them out there.

Senator Riegle. Those are important. That is exactly the kind of example that I think we have to get out into the light of day, because people of America don't want a system that is not working properly. I mean, once they understand what is going on—it may not be happening in their family right now, although it could any day, without warning—once people understand how these bizarre aspects have built up, I think the American people will insist on a change, will want a change, because it is good for the country, because it makes sense—the country gets stronger, once we make the changes.

Ms. McDonald. You understand it is also very cost-inefficient, because when a person gets so sick that he or she literally cannot work, and then is declared disabled, and then gets into Medicaid, the treatment is often very expensive.

Senator Riegle. It goes way up. It costs us more.

Ms. McDonald. Right, and they are usually terminal. It is just ineffective all the way around as public policy.

One of the areas the League has been into significantly has been data analysis in the last few years.

Senator Riegle. Let me stop you there, if I may. This is an important point.

I was asked by a reporter during the break period, "If we go to an intelligent, well-engineered health system that covers everybody, how much will it cost?" It is a fair question: what does it cost to do this? And there are various estimates, depending upon what you do, and over what time period you measure it, and so forth.

I am wondering if you would share this view: It seems to me, for precisely the reasons you just described, that if we invest in good health on the front end through a sensible system of insurance and care, we will actually spend less money than we are now spending. And this ties into the statistics that were given us as to the percentage of GNP we now spend on health care in our nation, versus the other industrialized nations. They are all providing the health insurance, but at a much lower overall cost.

Would you agree with the proposition that if we do this and do it right, we will actually end up saving money, because we will have healthier people and will catch problems earlier in time, instead of treating people when they are so desperately sick they can't get well, and the cost of the treatment goes way up because it is much more intensive?

The example was used of prenatal care. A little bit of money spent on prenatal care gives you a child that probably has a sufficient birthweight that it doesn't have to go into an incubator and have all of the special high-technology, very expensive cost that comes right after birth. And if you spend this much (a small amount), you avoid spending this much (a much amount). As a result, you don't end up by spending more, you spend less.

In other words, I think a comprehensive health insurance program will save money. I think we will end up spending less money, not more money; plus, we will avoid a lot of misery, a lot of heartache, and a lot of broken lives, which I think is worth a lot even if we had to pay to solve that problem.

But I think, in fact, we can do this in such a way that we can probably end up having the changes more than pay for themselves. Does that make sense to you, based on what you have seen.

Ms. McDonald. It would seem to, but we won't know for a certainty until we try it because insurance, even for people with excellent coverage often doesn't cover prevention and primary care services. You understand that. That is not the way the system has been designed, just for starters.

But, certainly, there are many health economists who believe that $450 billion a year is enough for comprehensive health services for all Americans, that we just need to redirect it within the system.

I think one of the worrisome aspects—and this comes out of our work with these projects, too—is that the insurance that small businesses can afford is often a very weak product; in other words, it has a lot of out-of-pocket expenses for primary and prevention services.

Access to health care is a different thing from access to insurance, and it is access to health care that we are after. Many insurance policies don't cover prevention and primary care services and thus don't increase access at the front—important—end. So a lot of the current answers, like use of extensive co-payments and large deductibles in policies so that small employers can afford to buy in, will not solve the problem. If you have a $500 family-deductible, I say that doesn't provide a lot of access to primary and prevention services for working-poor families.

So, as we structure a solution, we somehow have to get more coverage at the front end. I believe these people, and certainly their testimony today would support, that their access to health care is through the emergency room of a hospital.

Senator RIEGLE. Yes, which is the most expensive care there is. They are very sick, they come in at the last minute, and they have to get the most extreme, high-cost care there is.

Ms. MCDONALD. And the least creative approach to this and the only thing we hear about in making insurance affordable—and I say this as a small employer—is to increase deductibles, co-payments, and so on, and effectively increase out-of-pocket costs.

If you keep your eye on who we are trying to provide access for, and that is working-poor families—it is clear in all of the data that their need is the greatest, then you don't build a system to improve their access that is full of high deductibles and co-payments, because I maintain they will still have to come in through the emergency room.

Except that we will have infused the system with a whole lot of new dollars; we will have told ourselves, "We have fixed the problem," and 10 years from now we will come to the conclusion that it is not "fixed."

Meanwhile, I think the system is quite capable of absorbing billions of new dollars and providing medically-beneficial services with them without increasing access on the front end. One challenge is to find a way to do it that takes care that pooled funds get invested on the front end in primary and prevention services and low-cost therapies that work, and that is. A significant challenge but one we can meet.

That is probably a very long answer, but I was going to make this point anyway, because I really wanted to raise this issue. [Applause.]

I would say, in terms of one of the things that hasn't come up today and is a problem, and just a little background on the work that we have done, that while the problem of the lack of insurance is broad—our look at the data suggests that 17 percent of all of the families in Michigan have at least one person uninsured, so that it is broad—we also know that it is tied to economic status, and we know that it affects different ages differently.

Of Medicare people in Michigan, we believe 28 percent of them can't afford gap coverage and represent another highly under-insured group in Michigan. And, while Medicaid works well in Michigan—in this State we try to have a strong program and exercise all of the benefit expansion options available to us under the Federal law—it still is reaching only two-thirds of the people under the poverty level; and, if you look at people slightly above poverty, we are only reaching one-third; and if you get to people who are near poor by any standard, below 149 percent of poverty, we are only reaching 1 in 10. So, while I think Michigan is a progressive State with good policies, it has obviously got some problems.

We started, with others, a public-private partnership in Michigan to test some solutions. We all know there are problems, but what are the solutions to be? So, we started the Health Care Access Project a few years ago. We are the private part of it. Vern Smith, who is here, is the public part of it, from the Medical Services Administration in Michigan.

We also have in Michigan an active task force studying this issue—we are looking for solutions. Sandra Frank, who is the staff director is here; Linda Lane, who runs our access pilot in Flint is here. In Michigan, we are trying to test some solutions.

One of the efforts that people are the most interested in is the Health Care Access Project where we are testing a financing approach with small businesses which uses subsidy funds, some of which came from state government, some of which we raised privately. We ask small employers who hire people off of assistance rolls, and don't supply health care coverage, if they would supply coverage if their contribution was kept at one-third of the premium. We ask one-third of the premium from the employee, and we bring our subsidy funds to fill the other third. We call this part of our pilot the One-Third Share Plan.

Now, if you are very poor, if you are under 100 percent of poverty, we don't ask any contribution of you; we bring a two-thirds subsidy. If you are between 100 and 200 percent of poverty, we bring a one-third subsidy, and you have to pay your third; if you are over 200 percent of poverty, we don't bring any subsidy at all.

So we are testing this financing approach in Marquette and Genesee Counties, and we are about a full year into the project now from the first business that we enrolled, and we have had a very good look at the small business world.

I should note, in defense of small businesses, the National Manufacturing Association says their costs have tripled for health care insurance in 8 years, 30 percent in the last year alone, so that I think you can't just say they are heartless. I think, for some of them, it may be most difficult.

Of the businesses that we have approached, we found 41 percent of them were carrying insurance already, which is impressive; these are mostly small businesses that probably don't have a large bottom line. Nineteen percent of them couldn't participate with us, because we use criteria they could not meet; we are not dealing with the part-time work force or part-year work force, and so on.

To simplify: We contacted 1500 businesses, but let us just take a look at an average 100 of them and say 41 were already carrying insurance; 19 were ineligible; 32 said they couldn't afford it, even with us bringing a one-third subsidy to it and capping their contribution at one-third; and eight businesses signed up with us. So, we have 111 businesses, and we are learning a lot.

Senator RIEGLE. How many employees does that include?

Ms. MCDONALD. About 750.

Senator RIEGLE. Seven hundred and fifty that are in this experiment now?

Ms. McDONALD. Right. And we are looking for ways to continue this demonstration for another year and a half. So, I think we will have a sizable population.

What might be interesting is the business reaction. We have a few examples of business issues. If you have the time—if everyone has the time—Linda will tell you just exactly how these businesses are reacting and what they are saying.

[The prepared statement of Ms. McDonald appears in the appendix.]

Senator RIEGLE. Yes.

Give us a sense of that, Linda. Tell us a little bit about that.

STATEMENT OF LINDA LANE, DIRECTOR OF THE FLINT, MICHIGAN, HEALTH CARE PILOT PROGRAM FOR THE MICHIGAN LEAGUE FOR HUMAN SERVICES

Ms. LANE. In Genesee County we have contacted over 800 businesses, and we have had about 23 percent actually enroll, of the ones that are eligible.

When we talk to the businesses, they are all concerned with costs. A lot of the businesses we have talked to have looked at health insurance before and decided they couldn't afford it.

Our sense is that the real difference between businesses who are enrolling in our project and those that aren't are that the businesses that enroll have made a decision that health insurance is important to their business. Usually it is because the owner or a family members needs coverage, but not always. Usually that is the case.

The other ones say that the reason is cost. We don't know that the cost to them is any higher than to the businesses that are actually enrolling, because these businesses are all very similar in type and size. So the major difference seems to be those businesses have made a decision that this is important to them.

There are examples for every business and every person that we have talked to, and I am sure for all the million people in Michigan who are uninsured, but just a couple of examples to give you an idea of what these businesses in Flint are facing:

We had one business approach us because it is a small business, 10 employees, and one of the employees had a very expensive series of cancer treatments. The insurance company actually told the business owner that they would increase their premiums by 50 percent every 6 months until they were forced to drop their coverage. So they were out looking for other coverage.

Another business approached us because they had hired a woman from ADC—she was a single mother with a hemophiliac son. They had promised her that if she started working for them, they would offer her health insurance. She started working, dropped her Medicaid, and they couldn't find any that was affordable. So she was getting ready to quit her job and go back on welfare when they heard of HCAP and decided to go ahead and sign up with us.

There are more stories like that, but those are some of the things that are going on. We have been able to address some of that for people who are working in businesses that do choose to offer health insurance by helping them out with the costs.

Senator **Riegle**. Beverley, did you have something you wanted to add in addition to that?

Ms. **McDonald**. No, I just want to talk about the kind of businesses which are enrolling.

Senator **Riegle**. Please do.

Ms. **McDonald**. Just that they are about 10 years old in Flint. We think that new businesses often don't or can't offer coverage. In the upper peninsula they are 5 years or less which is a rather interesting difference. Basically, they are larger in the UP; they have more employees—they have about 6.5 employees, and they enroll about four per business. Basically the businesses fall into four or five areas: They are restaurants; they are auto repair or parts kinds of places; they are building or construction firms; they are retail stores; or they are providing professional services, and I mean here small accountants' offices, small attorneys' offices, and so on. That is how the businesses fall out. I will submit our first annual report for the record.

[The annual report appears in the appendix.]

Senator **Riegle**. You know, when you think about it, in theory, just sort of try to apply logic to it, if we think in terms of ourselves as a nation, 240 million of us, we are all important. We are all supposed to be equal under the law, with equal standing. We are all part of this team that comprises the country as a whole. And if we start from the proposition that we would like to have a healthy country—I don't think too many people would want to argue the other side of that; I would hope not—I would think most everybody would agree we ought to try to have a healthy country, to have everybody pretty well squared away as far as medical science and health science can enable people to be well and healthy.

If the need to see that that gets done is therefore in the national interest and something that is very important to the nation as a whole—rather than get all tangled up in having these individual businesses, large or small, struggling to try to see if they can provide it here or not provide it there, or do they just provide the insurance for the working mother and not for the rest of the family, or for the working father and not for the rest of the family, or if they provide the insurance here and the family has twins with Downs Syndrome, do the kids get coverage—I think what we have to do when we step back is to say to ourselves, "What we need for the good of our people and the good of our businesses is to have a kind of universal health insurance system." [Applause.]

Obviously we want very rigorous standards applied to it: We don't want it to be more expensive than it needs to be; we don't want to have poor quality service in it; we want it to be able to work efficiently when somebody has a health need, so that they get it diagnosed properly and it gets the kind of attention it needs, and so forth.

But I think we are at a point, if we just spend a little time thinking about it, where it is now very much in the interest of business, the nation as a whole, and all of us as individual citizens to have some kind of an insurance pool arrangement put together that provides a safety net—more than a safety net, because we not only want to deal with the extreme cases but we want people to be in good health all the time, because healthy people are able to not just have a higher quality of life but are able to produce more. I mean, we are going to have a country that performs at a higher level if we have got healthy people out there performing.

So it seems to me we finally have reached a point in our country where common sense tells us that restructuring this system with sensible and rigorous standards is good for everybody. Who is it not good for?

That doesn't mean that there aren't people today who maybe are really gaining great profits or gains from sort of the odd twists in the system—no disrespect to them, in terms of trying to pursue whatever economic opportunities there may be in a system that is not working properly—but from the point of view of the broad national view, that is not how we want to gear the system. We want to gear the system differently than that so that it really gets the job done at the least cost, and so everybody out there finds that they are not a second-class citizen or a no-class citizen.

I want to say, one more time, when you think about the stories we have heard here today, if we are not going to decide as a nation that we care about those two little boys who were in here, whether we ever meet them, whether they live on our block, live in our town, it doesn't matter. If we are not going to care about them and their parents, working as hard as they are to try to make ends meet, or that 28-year-old woman who was in here with Crohn's disease—in terrible pain, struggling, trying to work, trying to make ends meet, and not having the money to even go to the doctor when she is in intense pain—if these aren't the kind of American people that we are going to care about and that we are going to want to help when they desperately need help, what is the point of it all? Who are we going to help? Or are we just going to help nobody? Are we just going to help ourselves?

I think we have seen enough today to know, without having to bring every single walking-wounded person into this room—and there are tens of thousands in this State. We could have witnesses like those three come in here and tell stories like that for the next 12 months, 24 hours a day. I think we have heard enough here to know that it is time to fix that problem, and to understand that a decent society and an intelligent society will decide that it does not want problems like that going on any longer. We don't need to have that. Other countries are not tolerating it, and we don't have to tolerate it. It is an abuse of human beings beyond even the outer bounds of conscience, in my view, to allow people to suffer along under those kinds of circumstances when it is within our power to do something about it.

I realize that is a personal statement on my part, and everybody has to make up their own mind and have their own view as to what they think needs to be done and why, and so forth. That is the beauty of our system: we all get our say.

The lesson that I draw from today in terms of what we have heard—coming back, again, to those individual cases—is that it is time for us to move in on this problem. It is our problem. These are our people. They are like members of our family—they are members of our national American family.

We don't leave wounded people behind on the battlefield in war time; it is not our practice to do that. You know, in a war situation when people are wounded, we go and get them, and we do everything we can to try to help them get well, and so forth. And we can't leave our wounded people behind in our own society.

I think that is the great power of what we have heard from our witnesses today, that that is such a manifest reality as we sit here in 1989. We have got a job to do, and I am determined to see us do it.

Let me say a couple of other things here in concluding. Mr. Pat Babcock, who is the Michigan Director of the Department of Social Services, was here earlier. I don't know if he is still in the room, but I appreciate very much his presence here today.

State Representative Alma Stallworth was also here. I don't know if Alma is still here, but I appreciate her presence and participation, as well.

We also had, from the Southfield City Council, Vickie Goldbaum, who was here. I appreciate her presence. And there may well be other people like this who should be acknowledged.

The committee record will be open to receive additional statements from anybody who wants to make a statement. Anybody in the room who can give us a statement, or anyone not here who wants to file a statement for the record, will have 2 weeks from today to do that, to get that material in a form where it can be given to us so that we can make it a part of this committee record.

I know there are some people here who have indicated they want to speak to me about personal problems that have arisen that they are concerned about, and I want to try to do that.

We have promised our sponsors here that we would try to end this hearing at 1:00. We are a little past that time, but we are pretty much on schedule. So I am going to adjourn the hearing at this point. I will be here for a short period of time to talk to those people individually.

I want to thank everybody for their participation. It has been a very important, very valuable hearing.

The committee stands in recess.

[Whereupon, at 1:17 p.m., the hearing was concluded.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF C. PATRICK BABCOCK

SECTION I—INTRODUCTORY STATEMENT

I am C. Patrick Babcock, director of the Michigan Department of Social Services and co-chair of Michigan's Health Care Access Task Force. Governor James J. Blanchard appointed the 40-member citizen's task force in 1987 to assess the financial barriers to health care and to submit recommendations in 1989 for a statewide plan. Today, because those recommendations are not complete, I am testifying in my role as director of Social Services, the state agency which administers the Medicaid program. We appreciate the fact that the committee is examining this critical issue of health care coverage and access.

SECTION II—DESCRIPTION OF THE PROBLEM

Most people have health care insurance. Michigan's percentage of citizens with coverage (88.1%) is higher than the national estimate (82.4%). Despite this tradition of high insurance coverage, 977,900 Michigan people (11.9%) still have no health care coverage.

Recently, the uninsured population has expanded. Nationally, a 25% increase (37 million) from 1980 to 1987 has occurred. Current trends suggest that this increase will continue:

- Employment has been the most common link to insurance coverage, but it appears to be eroding (particularly for dependents) as employers face increasing health care costs.
- Job opportunities are increasing.but new jobs tend to be in small businesses and service industries traditionally less likely to provide health insurance.
- Reimbursement policies for providers (e.g., DRGs) cost containment and the emphasis on alternative delivery systems (PPOs, HMOs) have limited providers' ability to subsidize health care for the poor.
- Fiscal pressures at the state and Federal level have resulted in a decline in the proportion of the poor and near poor covered by public programs.

SECTION III—MICHIGAN INITIATIVES

A. The Governor's task force on access to heath care

Michigan's Task Force on Access to Health Care expects to issue a final report in 1989. One of the first initiatives was to commission a statewide survey of households. The Health Insurance Survey of Michigan (HISM) was conducted by the Institute for Social Research in Ann Arbor, Michigan. Preliminary survey information, initially reported to the Task Force one week ago, revealed the size and characteristics of the uninsured population in Michigan.

Survey Methodology

Statewide telephone interviews were performed in February and March of 1989 and included 1091 household interviews corresponding to 2938 individuals.

Population Size

11.9% of the population under 65 (977,900) do not have any form of health care insurance. If persons over 65 are included, 985,800 citizens do not have private or public coverage.

Age

The uninsured are a young population; nearly one third (313,500) are children 18 years and younger; another 22% are 19-25 years old. Nearly half of the uninsured (560,900) are below the age of 25! Only 0.8 percent of individuals 65 and over age uninsured.

Economic Characteristics

Income is directly related to the likelihood of having private health insurance: the lower the income, the bore likelihood of being uninsured. Almost 60% of the uninsured have incomes at or below 200% of the Federal poverty level: 41% are at or below the actual poverty level.

The Uninsured and Work

Almost 70% of the uninsured adults are employed (or temporarily laid off) and two-thirds of them work full-time. The workplace has always been the predominant source of health insurance in the United States, but that link is weakening.

Employment Status	Percent of Uninsured
Employed or temporarily laid off	67.3
Unemployed	9.8
Not in labor force	22.9

Health Status

The uninsured indicate poorer health than persons with private health care coverage. The uninsured are 62% more likely to be in fair or poor health.

Race

Non-whites are about twice as likely to lack insurance. Non-whites represent about 17% of Michigan's population but about 30% of the uninsured.

Education

Over 80% of the uninsured have a high school education or better. This is an educationally competitive group, many of whom are also employed.

B. Health care access project

Michigan is piloting an innovative approach to address health care for the uninsured. The Health Care Access Project (HCAP), developed by a broad consortium of public and private organizations, is funded by the Robert Wood Johnson Foundation "Health Care for the Uninsured Program" in two sites: urban Genesee County (Flint) and rural Marquette County (in Michigan's Upper Peninsula).

A major goal of HCAP is to determine the extent to which a subsidy can increase employer-based insurance. A second goal is to improve access to health care for persons who are indigent but who do not meet the categorical requirements for Medicaid.

Through its "One-Third-Share" plan, HCAP pays one-third of the cost when a small business (20 or fewer employees) elects to offer health insurance. The employee and the employer each pay one-third of the cost as well. The subsidy is available for employees whose wages are below 200% of poverty.

As originally implemented, the subsidy was available only to businesses which hired a public assistance recipient. Later, this requirement was modified for a one time, 90-day open enrollment period in Genesee County during which any small business could enroll.

As of June 1, 1989, 114 businesses are participating—40 in Marquette County and 70 in Genesee County—and the number is increasing. Employer-based health insurance has been offered for the first time to almost 800 employees and their dependents.

While the One-Third-Share Plan has been in effect now for only one year, the experience of this project already suggests some important conclusions.

1. Many small business owners will buy health insurance when the cost is reasonable.

2. Businesses that do not offer health insurance have many employees covered by health insurance. HCAP found that over 40% of the employees were already insured as a spouse or a dependent on a policy carried through another employer. In effect, businesses who offer health insurance are paying a large part of the health insurance bill for businesses who do not.

3. The high cost of health insurance is the single most important reason that businesses choose not to begin health insurance. Over half of qualifying businesses chose not to participate even with the subsidy because premiums were too costly for them. Employee health insurance premiums are higher for a small business than a large one.

4. The subsidy cost is relatively modest. Subsidies are being provided at an annual rate of about $200,000 ($150 per month per business; $46 per employee; $22 per insured person). Much remains to be learned from the One-Third-Share Plan. However, it is clear that a system of subsidies and incentives can make a significant difference in a business's decision to offer health coverage for its employees.

HCAP serves the indigent population that cannot qualify for Medicaid. Across this country, Medicaid provides access for a large and increasing proportion of the poor. (In fact, there is an increasing component of public assistance recipients who are working and on Medicaid. Over 33,700 [15.8%] working households are on public assistance in Michigan, up from 18,600 [7.7%] only four years ago.) However, it is ironic that Medicaid is least able to serve the very poorest of the poor—those who are single or childless couples—who cannot meet the aged, disabled or dependent child categorical requirements for Medicaid.

Under HCAP, a systematic health care coverage similar to Medicaid was created for this group. We learned that before HCAP, these persons did not readily seek medically necessary health care because it was a hassle.

Our HCAP experience points to the power of improving access through an improved Medicaid program. A Medicaid card can make the difference: a pregnant woman may seek needed medical care; a child or poor person may be able to afford the cost of health care without sacrificing funds needed for food or shelter.

SECTION IV—RECOMMENDATIONS

If progress is to be made in reducing or eliminating the number of persons without health coverage in this country, it is clear that a multifaceted approach is needed. Any single solution will leave a large number uncovered. A comprehensive strategy which I would recommend would include the following points:

1. More Effective Public Programs: At least 15 million Americans not connected to the labor force have neither public nor private health insurance coverage. For these persons, a more effective public strategy is required. Improvements to Medicaid are the best approach. Last year, Congress passed major legislation to extend Medicaid coverage as a transitional benefit to families who leave AFDC as a result of employment.

Under OBRA 1986, states were given the option to expand Medicaid coverage to 100% of poverty for pregnant women and children. OBRA 1987, gave states the further option to expand coverage for pregnant women to 185% of poverty and for children on a phased-in basis up to age eight to 100% of the poverty level.

The response of states to these options has been remarkable. Michigan is one of the 44 states which expanded eligibility for pregnant women to 100% of poverty. We are also proud to report that we have joined nine other states to increase eligibility up to 185% of the poverty level for pregnant women. States have been less quick to add' eligibility for children, however.

Several important proposals would utilize the Medicaid Program as a vehicle for otherwise uninsured pregnant women and children. These proposals deserve our most serious attention. In particular, we would support those proposals which give states the option to cover children in families with income up to 185% of poverty.

It is important that we do now what we can. It is important that we place our focus on the children who comprise over one-third of those who are poor and uninsured. This is a guaranteed investment in our future. Because children are not heavy users of medical services, it is the least costly group to insure. Clearly, the Medicaid Program provides an appropriate and effective vehicle for addressing the health needs of the uninsured poor and especially the uninsured poor children.

2. Employer-based Health Insurance: The backbone of health coverage in this country is employer-based health insurance. We should build on this system. The Health Care Access Project has demonstrated that incentives and subsidies can effectively encourage businesses, especially small businesses, to initiate health insurance. The single most important component of any strategy to reduce the number of

uninsured must involve a combination of incentives, subsidies and requirements which will bring health coverage to the 22 million uninsured Americans connected to the work force.

Bringing coverage to the working uninsured can be accomplished through:

- Tax code changes that bring parity in the tax treatment of health insurance costs for both corporations and unincorporated businesses;
- Devising a method to subsidize low-income businesses;
- Structuring the tax system to provide strong incentives for the business community to maintain their traditional responsibility to offer health insurance.

3. Universal Coverage: This is one of the wealthiest nations in the world yet we have glaring deficiencies in our current health care system. U.S. health care expenditures account for almost 12% of the GNP yet we have 37 million citizens without access to affordable/adequate health care.

We are the only industrialized nation in the world that does not have a universal health care system—particularly for pregnant women and children. Perhaps it is time to consider a long-term national policy that has "universality" as its primary objective.

I recommend a national policy that provides equal access and that does not discriminate on the basis of age, disability, family status or income. The plan could be founded on our traditional system of employer-based coverage. I would also encourage a restructuring of our current delivery system, moving toward a more efficient, cost effective model, e.g., managed care programs such as PPOs, HMOs, or Michigan's Physician Primary Sponsor Plan.

Finally, policy should reinforce and expand public programs to provide coverage for the most vulnerable populations and those who fall through the cracks.

It is clear that this approach must be primarily a national strategy. No state can long pursue a course of requiring universal employer-based health coverage if it is to remain competitive with its sister states.

SECTION V—SUMMARY AND RECOMMENDATIONS

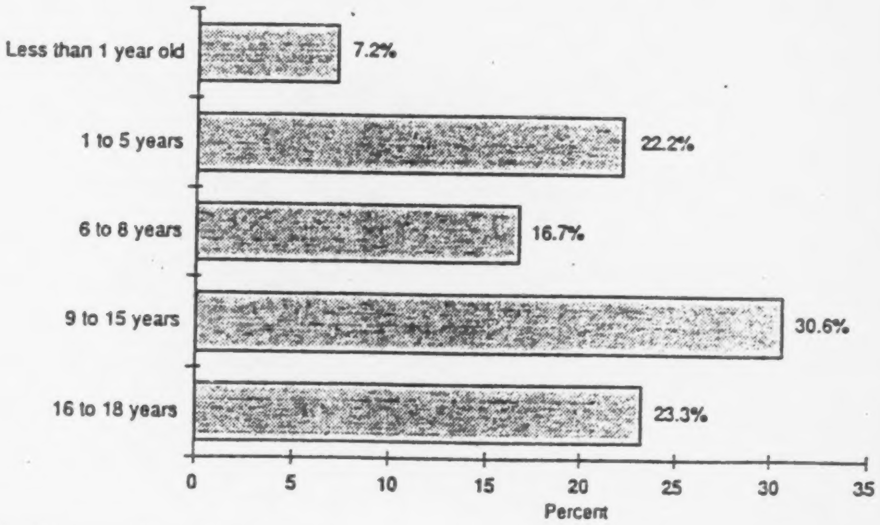
Unless action is taken now, the current trend toward increasing numbers of uninsured in this country will continue, and the situation will only get worse.

Unless we develop a broad-based strategy which relies on a public and private partnership, either the public or the private sector will bear an inappropriate and disproportionate burden in resolving the issue of the uninsured.

Unless financial access to health care is afforded for 37 million Americans currently without coverage, this substantial segment of our society will not seek medical care and we as a country cannot be a fully healthy society.

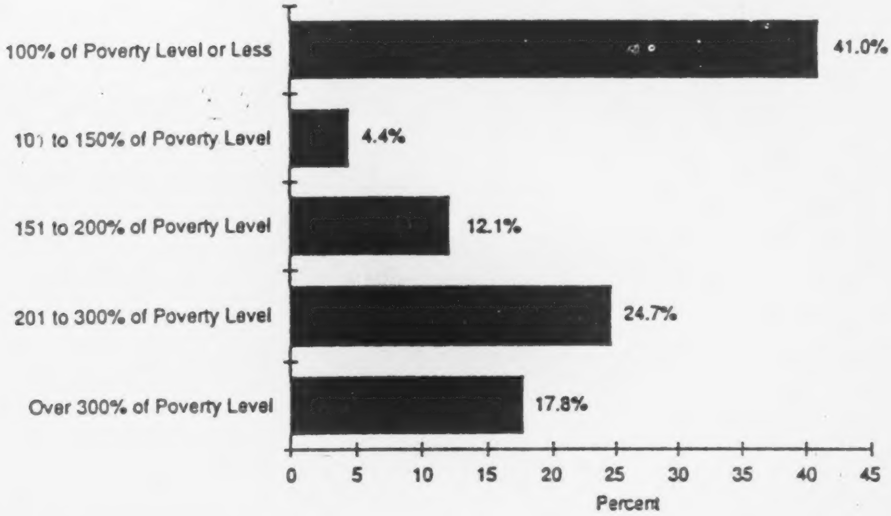
As the richest country with the most expensive health system in the world, we stand out as the only country that does not assure health care to all, including pregnant women, children, and even our poorest citizens.

Uninsured Children, 18 Years and Younger, By Age Group, in Michigan, 1989



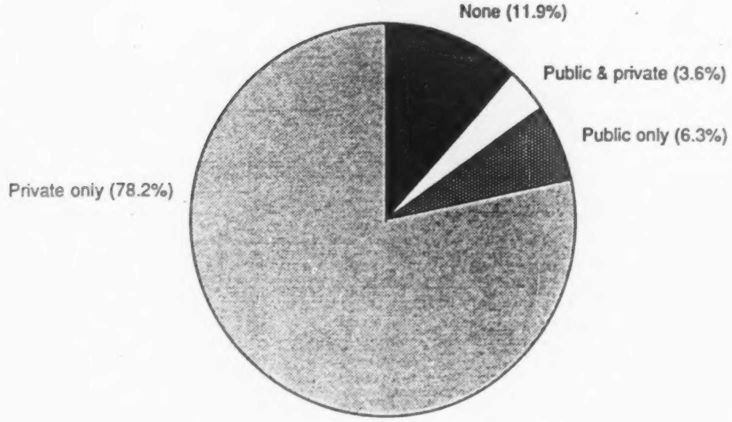
*Source: Health Insurance Survey of Michigan, 1989

Percent of Uninsured Individuals at Poverty Levels, in Michigan, 1989



Source: Health Insurance Survey of Michigan, 1989

Uninsured and Insured Individuals, 64 Years or Younger, by Type of Coverage in Michigan, 1989

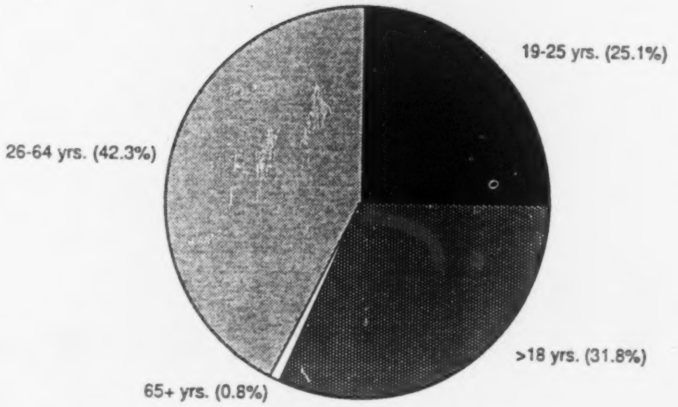


Source: Health Insurance Survey of Michigan, 1989

Type of Insurance	Distribution of Population	
	Estimated Percentage*	Estimated Number**
Both Public and Private	3.6	295,800
Public Only	6.3	517,700
Private Only	78.2	6,426,200
None	11.9	977,900
Total	100.0	8,217,600

*Source: Health Insurance Survey of Michigan, 1989 (n=2564)
**Source: Based on U.S. Census Bureau estimates of Total population in Michigan, as of December, 1988

Uninsured Individuals, by Age, in Michigan, 1989

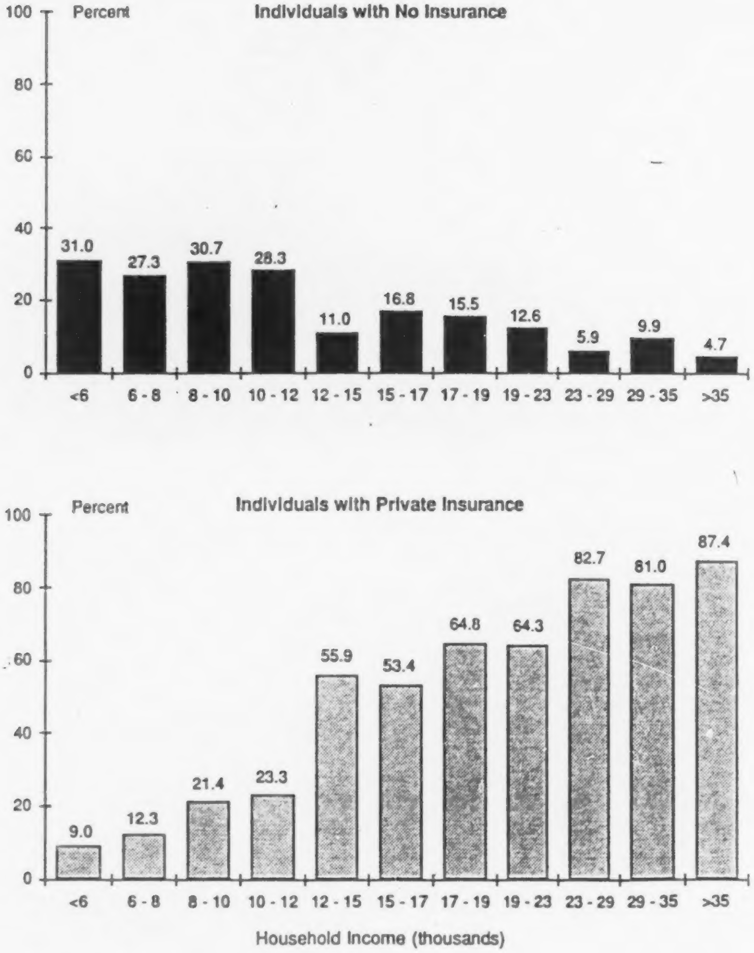


Source: Health Insurance Survey of Michigan, 1989

Age in Years	Distribution of Population	
	Estimated Percentage*	Estimated Number**
18 years or younger	31.8	313,500
19-25 years old	25.1	247,400
26-64 years old	42.3	417,000
65 years or older	0.8	7,900
Total	100.0	985,800

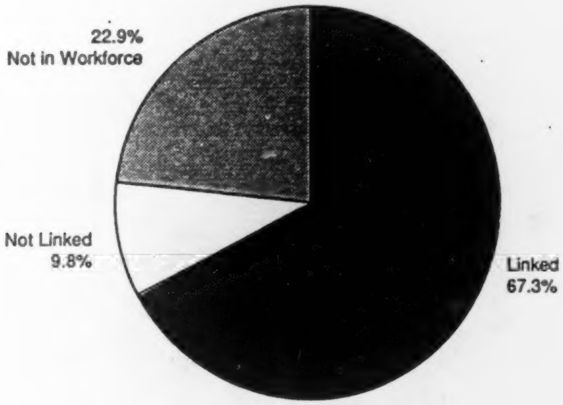
*Source: Health Insurance Survey of Michigan, 1989 (n=281)
**Source: Based on U.S. Census Bureau estimates of Total population in Michigan, as of December, 1988

Percent of Uninsured and Privately Insured Individuals Within Household Income Strata for Michigan, 1989



Source: Health Insurance Survey of Michigan, 1989

Uninsured Adults, 18 Years and Older, by Link with Employer, in Michigan, 1989*



Linked with an employer: Employed, Temporarily laid off, Self-employed.

Not linked with an employer: Unemployed and looking.

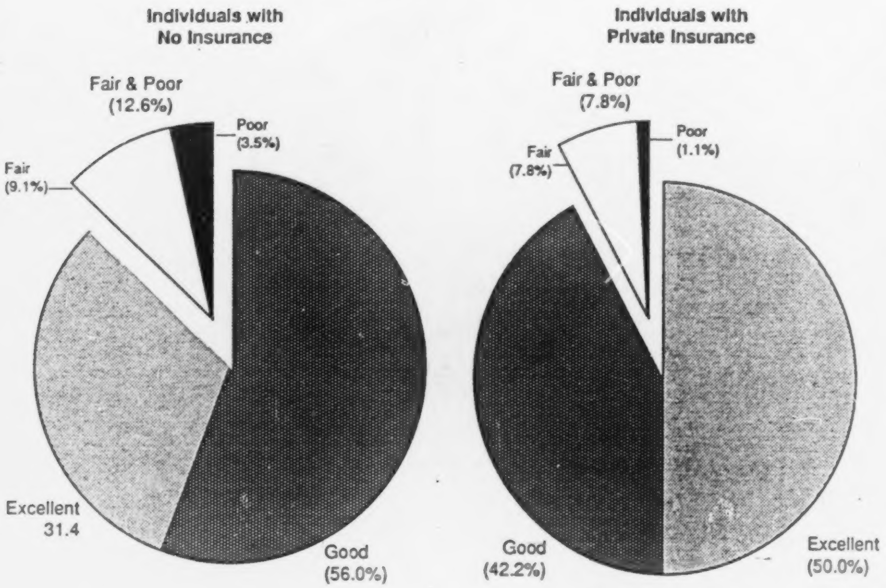
Not in Workforce: Retired, disabled, students, housewives, unemployed and not looking.

Source: Health Insurance Survey of Michigan, 1989

Linked to Employer	Distribution of Population	
	Estimated Percent*	Estimated Number**
Linked	67.3	477,700
Not Linked	9.8	69,600
Not in Workforce	22.9	162,500
Total	100.0	709,800

*Source: Health Insurance Survey of Michigan, 1989 (n=204)
**Source: Based on U.S. Census Bureau estimates of total population in Michigan, as of December, 1988
Estimate is for adults 18 and older

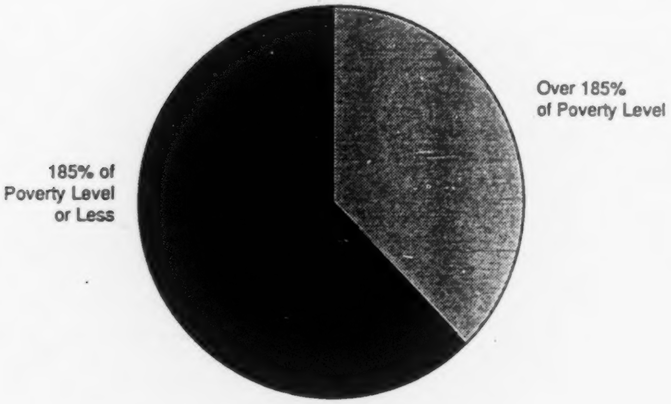
Health Status for Individuals with Private Insurance and with No Insurance, 64 Years and Younger, in Michigan, 1989



Health Status	Distribution of Population	
	Non Insured Estimated Percentage	Private Insurance Estimated Percentage
Excellent	31.4	50.0
Good	56.0	42.2
Fair	9.1	6.7
Poor	3.5	1.1
Total	100.0	100.0

Source: Health Insurance Survey of Michigan, 1989 (n=2555)

Uninsured Children, 18 Years and Younger, By Poverty Level for Michigan, 1989



Source: Health Insurance Survey of Michigan, 1989

Poverty Level	Distribution of Uninsured Children	
	Estimated Percentage*	Estimated Number**
185% of Poverty Level or Less	62.1	194,700
Over 185% of Poverty Level	37.9	118,800
Total	100.0	313,500

*Source: Health Insurance Survey of Michigan, 1989 (n=74)
**Source: Based on U.S. Census Bureau estimates of total population in Michigan, as of December, 1988

NRY FORD HOSPITAL

ALYSIS OF MEDICAID UNDERPAYMENTS AND

N-MEDICAID UNCOMPENSATED CARE

	1985	1986	1987	1988	Total	Total Change Three Years 1985-1988	
						$	%
icaid Underpayments:							
npatient	($449)	($2,527)	($3,525)	($4,341)	($10,842)	($3,892)	866.82%
utpatient	($3,281)	($2,842)	($3,695)	($4,011)	($13,829)	($730)	22.25%
D Services	($7,074)	($7,064)	($7,350)	($7,554)	($29,042)	($480)	6.79%
Total Medicaid Underpayments	($10,804)	($12,433)	($14,570)	($15,906)	($53,713)	($5,102)	47.22%
-Medicaid Uncompensated Care	($10,507)	($12,794)	($13,784)	($13,992)	($51,077)	($3,485)	33.17%
Total	($21,311)	($25,227)	($28,354)	($29,898)	($104,790)	($8,587)	40.29%

PREPARED STATEMENT OF DAVID W. BENFER

I am David Benfer, Executive Vice President of Henry Ford Hospital, and Group Vice President of the Henry Ford Health care Corporation, Detroit, Michigan: Thank you for the invitation to comment on the issue of access to health care for the uninsured.

Health care for the uninsured is a growing concern in Southeastern Michigan. Overall, more than 1 million people in Michigan are without some form of health insurance coverage. 49% of the uninsured are thought to be in Southeastern Michigan, and estimates place about 350,000 of them in Wayne County. Thus, the percentage of people without insurance in the Henry Ford Hospital primary service area may be as high as 20%. In addition, a substantial number of people in the Wayne County area are eligible for Medicaid.

One way to measure the level of need is to look at the amount of uncompensated care hospitals currently provide and what the trends are. (Governor Blanchard's Access Task Force will soon be producing better local numbers regarding the need in various parts of Michigan.) At Henry Ford Hospital, we currently finance $14 million per year for uncompensated care and will absorb an additional $16 million in Medicaid underpayments this year. This financial burden has grown more than 40% over the past three years (attachment 1). Such costs are not unusual for similarly situated hospitals located in Michigan central city areas. For example, southeastern Michigan hospitals saw their uncompensated care (exclusive of Medicaid underpayments) grow from $140 million in 1985 to $196 million in 1987 (attachment 2).

Care for the poor has traditionally been available at community hospitals. This care was supported by a technique known as Robin Hood financing or cost-shifting. That is, hospitals, including Henry Ford Hospital, have been able to keep the doors open to people unable to pay for their services by shifting the costs for providing free care to other customers of the hospital.

What has changed to make cost-shifting less tenable in today's world? Basically, two things: First, cost-containment efforts by large purchasers, including the large employers and the Federal and state governments, have reduced the ability of hospitals to cost shift. Second, the total cost for uncompensated care that has to be financed has grown dramatically as the number of people who can't pay has increased, and overall costs for health care continue to increase (due to technology, aging of population, etc.)

The traditional cost-shift financing for uncompensated care works when large payers, like the Blues and self-insured employers are willing to subsidize. But overall cost-containment strategies generally translate into fixed pricing arrangements that minimize the large payor (including the State and Federal governments) exposure to cost-shifting. In the June 19 issue of Crain's Detroit Business, local business executives identified containing business health care costs as a top priority. With fixed pricing as a growing cost-containment strategy, the margin that has traditionally existed to pay for charity care (and off set Medicaid underpayments) is disappearing.

Henry Ford Hospital's present payor mix is indicative of the cost-based to fixed-price reimbursement trend. Today, more than 80% of our business is fixed price. Six years ago, that number was less than 15%.

PAYOR MIX (1988-89)

Payor	Percent of Revenue
Medicare	32.6
HMO	25.2
BC/BS	18.6
Medicaid	15.3
Self-Pay	2.2
Other	6.1

I'm not here to defend the old cost-shift system. It's expensive and inadequate. Our data indicates that a large percentage of unsponsored patients are delaying care until a emergent condition occurs. We track payor mix in our ER and the numbers reveal that about 20% of the services provided in the ER are for unsponsored patients, compared to less than 10% of admissions for such patients. A simple extrapolation would suggest thousands of people in Michigan have limited access to care and delay care until it results in an emergency room encounter.

While you can expect us to do everything in our power to survive in this very competitive and rapidly changing environment, there are a number of factors beyond our control that affect our future as individual institutions; chief among them is the problem of financing care for people who can't pay and don't have insurance.

The current system is not working. More dollars are required just to stay even with the existing programs for the neediest members of our society—the very young, the very old and the very poor. Critical indicators such as infant mortality, place parts of Michigan at the bottom of the list. Millions of people don't get basic care because they can't pay for it and don't have insurance. In addition, the pool of individuals entering the work force will shrink during the next decade, requiring greater attention by employers to the health care needs of their workers. The question is, where do we, as a society, look for solutions?

In today's system, those who pay for health care act as the voice of the patient. Under this system, there are 37 million uninsured Americans who have no voice. We believe the congress has to be the voice for this group of citizens. Henry Ford Health Care Corporation, along with many hospitals, have specifically expressed support for senator Kennedy's Employer Mandate approach. From our perspective, any plan that (1) eliminates financial barriers to basic health care, and (2) assures that providers (hospitals and physicians) are not competitively disadvantaged because many of their patients can't pay for care is acceptable. Senator Kennedy's bill is a big step in this direction for low income people who have jobs. From my perspective, Medicaid expansions and better Medicaid funding is also overdue.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated in its report to the President in 1983, "Private health care providers and insurers, charitable bodies, and local and state governments all have roles to play in the health care system in the United States. Yet, the Federal Government has the ultimate responsibility for seeing that- health care is available- to all when the market, private charity and government efforts at the state and local level are insufficient in achieving equity."

Our mission as an organization is to try to continue to serve in the best way we can. We have no intention of backing away from the people of the City of Detroit and people without the ability to pay. The Federal Government currently helps in this regard.

Henry Ford Hospital carries one of the largest loads of people who can't pay in the entire state, and we train over 470 medical interns and residents, as well as 160 nurses and 45 allied health students. Many of the professionals trained at Henry Ford stay in Michigan and a large percentage remain to practice in the inner city. Those who stay in Detroit often will serve to train others to follow them. The Medicare program recognizes health manpower needs and service to low-income people by providing targeted support to strengthen institutions that contribute in this regard. In 1988, Medicare adjustments to Henry Ford Hospital for education and care to low income people—constituted about $30 million. These payments are directly related to our ability to finance care for the uninsured. Stated another way, any reductions in Medicare payments for Direct and Indirect Medical Education costs or Disproportionate Share payments, directly adds to the current $30 million we now finance for unsponsored care at the Henry Ford Hospital. We are concerned that the current discussions in Congress about reducing Medicare hospital payments will erode the present Federal effort to support uncompensated care costs.

The Medicare program provides Henry Ford Hospital with supplemental payments in recognition of our role in this community as a major source of care for low income people and a major training institution for health care professionals. We respectfully urge that such efforts be maintained as you search for long-term solutions.

To summarize, new linkages between the private sector and government are needed to ensure adequate, cost-effective health care for everyone. Government, employers, private payers and health providers have to work together to achieve broad-based solutions. I personally believe basic health care is a right for every citizen. I pledge our support-to your efforts.

(2)

Table 4

Counties	General Assistance Average Monthly Cases	RCH Expenditures	RCH Per Capita Expenditure	Hospitals Uncompensated Care	Hospital Per Capita Uncompensated Care	Per Capita Uncompensated Care / Per Capita RCH Expenditure
Livingston	283	$0	$0	$870,272	$ 8.27	$8.27/$0
Macomb	2,001	$ 1,231,796	$ 2.74	$7,386,912	$10.45	$10.45/$1.79
Monroe	1,425	$81,595	$.62	$ 792,735 [1]	$5.98	$5.98/$ .62
Oakland	4,747	$2,677,548	$2.61	$32,620,512	$31.79	$31.79/$2.61
St. Clair	2,062	$ 331,568	$2.23	$459,914	$32.29	$32.29/$2.33
Washtenaw	1,375	$0	$0	$26,432,598	$95.48	$95.48/$0.00
Wayne	70,313	$49,854,516	$22.74	$120,906,944	$55.16	$55.16/$22.74
S.E. MI 1987	82,206	$54,177,023	$11.82	$196,000,000	$42.77	$42.77/$11.82

[1] Bad debts only

(3)

HFH

Emergency Room Payor Mix

BC/BS	15%
Medicare	24%
Medicaid	19.6%
*Private	21.2%
Commercial	3.2%
HMO	17.0%

*Includes uninsured and a very small number who are self-pay.

Population Wayne County
State Demographic
Department of Management & Budget, Lansing

1990 Estimate Wayne County Population
2,156,600

Environment Assessment
SMSA & Outstate — Wayne, Oakland, Macomb, St. Clair & Lapeer

Detroit

% Insured	89%
% Uninsured	11%
	490,689

1987: Southeast Michigan Population
4,583,133

1987: Southeast Michigan Hospitals Uncompensated Care
$196,000,000 (charity and bad debt)

Uninsured

A. (1) million - State of Michigan

B. 49% of total (1) million in state are estimated to be in Southeast Michigan

C. 350,000 estimated to be in Wayne County

HFH Data

Licensed beds: 937

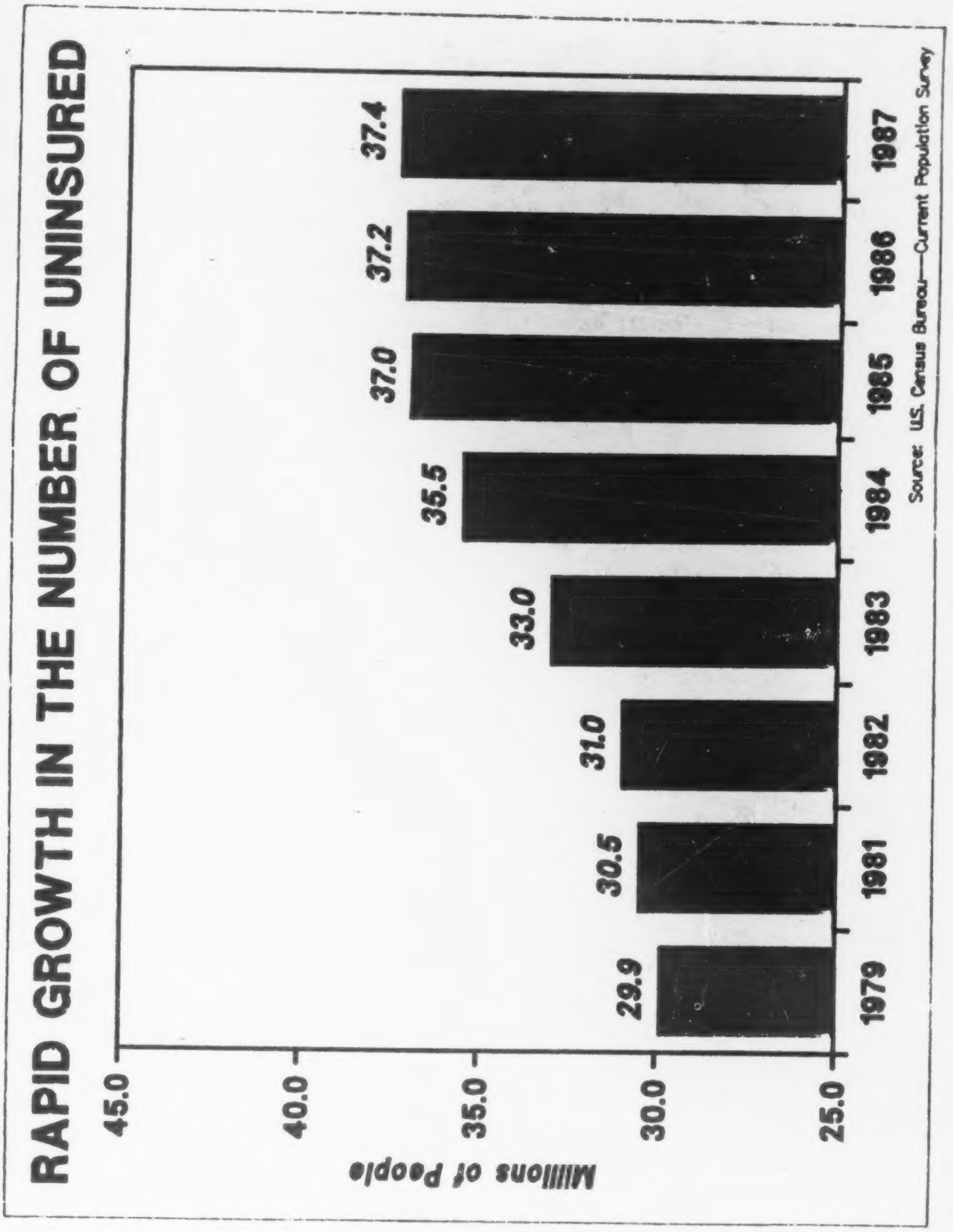
% Medicare	28% Admissions 34% Days

1988

Total Days: 293,630*
Total Admissions: 37,345*

% Medicaid	16% Admissions 14% Days

*Exclusive newborn or prenatal



RAPID GROWTH IN THE NUMBER OF UNINSURED

Source: U.S. Census Bureau—Current Population Survey

Prepared Statement of Michael C. Boucree

Health Care for the poor and the uninsured has often been called or described as "**fragmented, episodic, crisis-oriented** and **underfunded.**" Unfortunately, though strides have been made to correct this gross inadequacy, complacency and disregard for this system of health care has set in.

As the Medical Director of a community health center, which is one of the only federally developed initiatives designed to deal with this population, it is my view that inequities in the delivery of health care to the indigent, funding of care for the indigent, manpower resources; to care for the indigent, and general lack of concern for the medical and social problems of the indigent are ever evident and increasing daily. This impression is further substantiated by President Bush's "kinder and gentler America" and his inclusion of community health centers in the "Black Box"—which as you know are a group of programs set to have drastic reductions in funding (if not completely slashed), in order to reduce the national debt.

Community Health Centers have as their mission the delivery of comprehensive primary care services to the medically underserved, regardless of race, color, creed,sex, or the ability to pay. *The uninsured compose approximately 30–50% of the Community Health Center population in Michigan, according to the Michigan Primary Care Association.*

WHO ARE THE UNINSURED WHO USE THESE CENTERS?

Seasonal and migrant farm workers, Hispanics, Asians, Whites, Blacks, Indo-Chinese, American Indians and Haitian refugees. Interestingly however, they do not all fit the stereotypical "uninsured" person which might be thought of. Many are employed and their employers simply cannot afford the cost of providing insurance coverage; and therefore, must seek providers of care who will accept them as *charitable* or potential *bad-debt* cases, and/or receive truly episodic, crisis-oriented care because of the cost of the office call. They are young, school-going teens in need of care for clinical problems as simple strep throat and sexually transmitted diseases, to serious problems as sickle-cell crisis and diabetic coma. They are increasingly persons who are employed by one of the major car manufacturers in Michigan but who have now been laid-off and have lost their Blue Cross/Blue Shield benefits or HMO carrier benefits.

They are those who seek sanctuary at a facility where **concern compassion** and **interest** in their medical, dental, or mental-health problem and treatment for that problem, regardless of third party payor is the rule and never the exception. Since 1965, when Neighborhood Health Centers were established, these persons and hosts of others have sought health care at our centers, but with radical changes in funding status and reimbursement, these facilities face a tragic demise with the result being the loss of access to health care for many people who, for obvious reasons, could not afford to go elsewhere!

WHAT SERVICES ARE REQUIRED?

Primary health care encompasses a broad range of services which in essence are services that are received at a users point of entry into the health care system. It must basically include:

(1) A diagnostician, portrayed in the role of a physician, physician assistant, nurse clinician, or a dentist,
(2) Diagnostic Services (both laboratory and radiographic),
(3) Emergence Medical Services,
(4) Preventive Health Services, and
(5) Education and Counseling Services under the heading of health promotion/disease prevention

Consequently, providers of primary health care are responsible for the vast majority of referrals to secondary and tertiary providers.

In the delivery of primary health care services and understanding the problem of primary health care service delivery, we can look at it through 5 critical elements:

(1) Accessibility
(2) Comprehensiveness
(3) Coordination
(4) Continuity
(5) Accountability

It is through these fundamental elements of primary care I will bring you into the world of the uninsured as they travel through the maze of health care.

Accessibility

Reports document that:

—one in 6 **blacks** and one in 4 **hispanics** is completely uninsured compared to one in 11 **whites;**

—persons who have no health insurance are 50% less likely to receive needed **physician's services** and 90% less likely to receive needed **hospital care;**

—an estimated **37 million Americans** which reflects 13.5% of the nation's civilian, noninstitutionalized population have **no private insurance or public coverage** to help pay medical needs. Nearly one half are from low-income families and almost one-third are children;

—one million Americans annually are **denied health care** because they cannot pay-for it and an additional 14 million do not even seek the care they need because they know they cannot afford it;

—**homelessness** is an ever increasing population in America and many are not even eligible for governmental or state entitlement programs. These persons do not even know **where to go** for health care much less to determine or identify **how they will pay** for the health care they receive;

—persons who are infected by the **human immune deficiency virus (HIV)** have no provider to turn to because of fear of rejection, poor quality care and abandonment not only because of their diagnosis, but because of their inability to pay, thus increasing their morbidity and hastening their premature death;

—disproportionate high **infant mortality** rates for black mothers opposed to white mothers because of lack of accessibility to a health care system;

—untreated **substance abuse** problems increase because of a lack of monetary funds to seek professional health care for guidance to counseling and rehabilitation services.

Through enhanced funding availability, existing community health centers would be able to advertise their ability to serve the population at large and acknowledge their expertise in diagnosing, treating and managing primary care illnesses and utilize the resources and linkages they have available and thus reduce the poor and undesired outcomes to many preventable and treatable diseases; further, this enhanced funding would **allow** development and establishment of health centers in critically needed areas where there is an unmet need, which totals 25% according to a recent study by the Michigan Primary Care Association (MPCA).

In short, accessibility refers to the ability and ease to with which one can seek and receive health care without insurance. As a mission objective of community health centers, we have provided this avenue, but the demand for our services far exceeds our ability to accommodate these persons and must therefore, unfortunately, limit the 33 million Americans who need us. Those who do access our services are placed on a **sliding fee scale** according to household income, and receive medical, dental, and counseling services based on their income.

COMPREHENSIVENESS

After matriculation into a system of health care, a whole new world may exist. Should a problem be too difficult for the primary care physician to handle or hospitalization, rehabilitative, or special educational services become needed, the client must be referred to a system which can manage this problem. For without this ability, the first component of health care service delivery (accessibility) is violated.

Health care providers in community health centers through the support and facilitation by the Administrators are likely to have established linkages with local community agencies arid hospitals to provide services beyond the scope of primary care intervention. As such, the patient with chest pain who has sought care at the community health center can have the benefit of a cardiologist evaluation if needed and/or non-invasive or invasive diagnostic cardiology procedures to determine the causes of the patient's chest pain. This is usually performed at the discounted rate or charitable fee to the patient.

However, due, to the unfortunate **malpractice issue** beleaguering Michigan physicians and physicians nationwide, they are reluctant to see any patients without insurance because of the reported litigious nature of uninsured clients, the risk of their practice becoming known as the **"poverty doctor"** practice, and the loss of income resultant from treating a number of uninsured clients without subsidy. To compound issues, public hospitals are facing rapid closures because private hospitals are not willing to accept charity cases, and therefore the uninsured cases are all "shipped" to the public hospitals. Local and Federal agencies are drastically reducing funding to the public institutions in attempts to make them more self-sufficient. Yet, while this maturity has developed clinically, the economic climate has stifled further growth and placed limits on their expenditures while mandating they meet the demands of the public health need on a "shoe-string" budget. Further, agencies may not accept patients into their substance rehabilitation programs because of a client's uninsured status. These issues therefore provide secondary barriers for access to true comprehensive health services.

Community Health Centers are usually capable of providing the access to these services by virtue of **informal and formal, non-monetary agreements with private practitioners, hospitals and agencies** to provide for the needs of their clients.

COORDINATION/CONTINUITY

Once the client accesses the system, and is referred to a specialist for specific treatment, the questions of **health promotion/disease prevention** activities, of **health maintenance,** and "family doctor" must be answered.

That is, once the immediate clinical or social problem has been addressed, ongoing therapy must be continued and a harmony between the consultant and primary physician must be effected in an ongoing fashion. Further, in the event an unrelated illness should arise, the patient should be able to maintain the relationship with the physician at the point of initial contact.

It is unfortunate that many persons who are uninsured see the **Emergency Room** as their place for primary and consultative medical needs because of either the lack of a physician to coordinate their care or the lack of a physician to provide care on a continuous basis. "By making high quality primary care available, community health centers have been effective in persuading poor families to end their reliance on more expensive and less appropriate emergency rooms. Families also learn to make use of preventive health services Health Center patients use more primary health care and are better Immunized. *Forty percent of all health center visits are for preventive and health maintenance care* and a greater percentage of health center patients receive physical exams."

The responsibility for performance, delivery, coordination and follow-up of these activities generally fall to the physician as he/she is "the attorney for the poor," as the scientist Virchow put it. However, in a community health center, where there is a very high patient-to-provider ratio, by virtue of its administrative and clinical support structure, nurse clinicians, social workers and in rare cases, case managers coordinate the care for the patient under the guidance of the primary physician and facilitate a smooth and healthy continuance through the life

ACCOUNTABILITY

This final element embodies several different aspects intangible to the primary care recipient Primarily, they are:

(1) quality of care assessment
(2) reimbursement
(3) mission objective satisfaction

It is a common misconception that care rendered to the poor is poor because not much can be done. However, the care and consideration rendered to one who has no insurance should not differ from one who has insurance. After All, the insurance should not determine the quality of care provided, the one who provides the care should! **"Health centers have achieved a very high level of satisfaction among the patients they serve. One study showed that center users rated centers higher (by 2 to 1) than any other major source of health care, including private physicians, because of their quality, comprehensiveness, attentiveness and convenience. Those interviewed said that they would choose health centers even if other providers offered care free of charge."**

Our centers are funded under **Section 330 of the Public Health Service Act,** and in some cases under the Stewart B. McKinney Act, and we therefore are able to subsidize the cost of the discounted office call, x-ray and/or lab procedure, and any other onsite service for our uninsured clients. However, as persons with **Medicare** and **Medicaid** find it difficult to find providers to accept their form of insurance," they seek care at our centers and our grant monies must be stretched to offset the low reimbursement of these carriers Approximately 50–60% of the Community Health Centers population fall into this category. Of the uncompensated care, which is approximately 30–50% of the clientele, a large percentage of this income must be written off as bad-debt. It is here that our Federal monies should be used but, cannot be because of the above. According to the American Medical Association, a recent survey cited that of the 76.8% of physicians in fee for service practice who provided care to the uninsured, these practitioners experienced a 9.1% average reduction in potential revenues with 6.3% of the total practice billings never being collected.

As a **non-profit organization**, by definition, we are not interested in making a profit. However, we are mandated by the Federal Government to collect and reduce our dependency on Federal funding. However, whether we want to or not, our dependency is being reduced because of reduction in Federal and State dollars, yet with this reduction there is a concomitant rise in demand for our services. And therefore the groundwork for the controversy over care for the uninsured increases and the dilemma in effecting the balance between advertising for service delivery and capability for service delivery is set.

In summary, "the poor and sick should be given some care because to give such care reflects the best ideals of how we want our physicians, citizens and society to be. The highest motive for treating the sick [and poor] is . . . the highest form of moral excellence." The facts presented here only scratch the surface of the **plight of the uninsured in their quest for health care.** But through it all, our health center, *Hamilton Family Health Center*, like other Community and Migrant Health Centers in Michigan and across America are able to proudly stand and recite our mission and feel comfortable that we are meeting our program and mission objectives without failure.

Prepared Statement of Senator John H. Chafee

Mr. Chairman, I commend you for holding this hearing. Unfortunately, a prior commitment prevents me from being here today. I intend to study the testimony very carefully because I believe that one of the most serious and troubling problems we face in this country today is the number of people, especially children, who are without any health care coverage.

Providing access to health care for all Americans is a matter both of moral responsibility and of economic necessity. Why? Because it is wrong for anyone to become ill simply because he or she does not have access to primary and preventive health care. Because it is wrong that emergency rooms are often forced to provide that primary care. Because it is inefficient for our health care system to pay for illnesses that could have been prevented.

If present trends continue, American business will confront a serious labor shortage in only a few years. By 1990 the impact of new technologies is expected to drive total private sector demand for employment to 156.6 million jobs—nearly twice that in 1978. Small businesses are already having difficulty filling available jobs. Even if these estimates are only close to the mark, there will be a shortage of over 23 million Americans able to work.

As the percentage of children in our society continues to decrease, our labor shortage will become even more acute. Not only will there be a lack of qualified job seekers, there will also be a simple lack of people to become qualified.

We cannot afford to allow any potential worker to become afflicted with a serious illness which could have been prevented. This applies to infants, children, and teenagers as well as those currently in the workforce. In order to prevent such illness, these individuals must have access to good and affordable health care.

One of the most obvious examples of this is the debate in both the private and public sector over prenatal care. Prenatal care is perhaps the most cost effective of all health care services. Yet, there is a great deal of reluctance to cover it. How absurd. It costs about $700 to give a mother a proper prenatal care package. On the other hand, care for a low birthweight baby costs at least $7,000. The care of a baby born with a developmental disability can exceed one million dollars over its lifetime.

When you think of this in terms of investing in our future, the reluctance to provide appropriate health care is astoundingly short-sighted. Quite simply, given our economic situation and our concern for the future this is an investment we can not afford to avoid any longer.

It is for many of these reasons that in the last Congress I introduced MedAmerica, S. 1139, which would substantially expand the Medicaid program to offer health care coverage to the neediest of those who are currently uninsured.

MedAmerica would build on the existing Medicaid program in four ways:

First, it would sever the tie between Medicaid and cash benefit programs—such as AFDC and SSI. With a few exceptions, only those who are eligible to receive welfare can get Medicaid benefits. As a result, on average only those who are under 48% of the poverty level are currently receiving medical assistance through Medicaid. Under my proposal, states would have the option of providing Medicaid benefits to anyone whose income is below the Federal poverty level, which is $6,000 for an individual and $12,000 for a family of four, regardless of whether or not they qualify for welfare.

Second, it would allow individuals—the so-called "working poor"—whose incomes are between 100 and 200 percent of the Federal poverty level to purchase health insurance through Medicaid for an income-adjusted premium, not to exceed 3% of the individual or family's adjusted gross income. This provision would allow a family of four with an income of below $24,000 to purchase Medicaid insurance.

Third, it would allow persons with family incomes and resources in excess of 200% of the Federal poverty level to purchase Medicaid for a non-income adjusted premium if they have been excluded from private health insurance coverage because of a medical impairment or disability or if they have exhausted one or more benefits under their private insurance plans.

Finally, the bill would allow businesses of less than 25 people to purchase the MedAmerica plan for their employees if they can not find comprehensive health insurance at a reasonable cost in the private sector.

If all of these provisions were adopted, MedAmerica would cover about two-thirds of the 37 million who currently have no health insurance coverage.

I introduced this proposal because I felt that discussions on how to deal with the issue of the uninsured and the underinsured were overlooking an important option: the use of an existing public system. Even if Congress were to mandate that business provide health insurance to all employees, we would still be missing a large portion of those currently without coverage.

Some people have been critical of the idea of expanding a Federal program in a time of high deficits. I don't agree with them. I do not believe we can afford to ignore the health care needs of our citizens any longer.

What are our options for financing?

I believe that a combination of private and public sector involvement and financing is necessary. The real access problem is for those who are in lower wage jobs and with smaller companies that are operating with limited cash flow. Small businesses have a particularly difficult time finding reasonable rates for health insurance and as a result, they rarely are able to offer the benefit to their employees, let alone the employees' families.

MedAmerica as introduced does not address the financing issue and I am currently working with concerned individuals and organizations, to arrive at a method of financing which will allocate costs fairly and treat universal access to health care as a shared responsibility.

Once again Mr. Chairman, I commend you for holding hearings on this critical issue.

PREPARED STATEMENT OF DAVID DILLOWAY

My name is David Dilloway. I am here today to talk about my wife Arlene and our experience with the health care system.

My wife is a diabetic. She has been a diabetic for over 15 years. These last 6 years, she has been on insulin. We have had health insurance off and on during this time, but were lucky because she never needed any major medical treatment. When I worked union, they paid for part of our insurance. When I worked non-union, however, I wasn't entitled to any benefits. For a short time, I was on ABC and we received Medicaid. Now I have gone back to work and there is no medical insurance offered. This is not unusual because small companies can't afford to supply insurance for sub-contractors which is how I earn my living.

Part of the Arlene's medical problems started back in 1984 when she got a piece of wire in her foot. The doctors misdiagnosed her and consequently she lost two of her toes. As a result of the diagnosis, we received a small legal settlement. We hoped the settlement would enable us to purchase health insurance, but because of Arlene's diabetes, know one would insure her. I went through the telephone book and tried at least 20 different insurance companies. It didn't matter that I had the money. No insurance company would take her because of her pre-existing condition.

In January of 1988, the night of the Super Bowl game, Arlene developed severe stomach pains. We called the doctor and he said that because we didn't have health insurance, he would meet us at his office and he would check on her condition. He gave her a shot of Demerol to kill the pain and calm her. Her doctor continued to give her shots of Demerol and other pain-killing drugs. He also ran several tests, including an Ultra Sound, and a Cat Scan at the Lapeer County Hospital (LCH). After the all those tests, he did not know what was wrong with her and referred her to the University of Michigan Hospital

After 3 weeks of waiting, Arlene received her first appointment at the U of M Hospital. After a special test, the doctors found blood in her stool and ordered a colonostomy to be performed on her the next day. At first glance, they thought she might have an ulcer but they weren't sure. They put her on some Ulcer medication for 3 weeks until her next appointment: Before she had a chance to go back, however, the pain suddenly moved into her right side. This meant that it was not an ulcer but rather a problem with her gall bladder. The doctor told us that she would have to have it removed. At this point, we had over $2,000 in outstanding bills. We had no insurance and we were quickly falling into debt. We were not even thinking about the money, until the U of M Hospital administration informed us that we would have to pay $5,000 in full before they would perform surgery on Arlene. The Administration cited that Arlene's surgery was considered elective and therefore not immediately necessary. Even though the doctor insisted that Arlene's gall bladder should be removed immediately, the hospital refused to admit her without complete payment. This was the first hospital that refused to treat her. I kept thinking to myself—what am I going to do?

Since we couldn't afford to pay U of M that large amount of money, we decided to return to LCH. They had seen her before and knew what was wrong with her. Before they would treat her, however, they made us sign a paper indicating that we would pay $200/month. We had no choice but to sign the paper. LCH ran more tests on Arlene. These were the same tests that the U of M Hospital had just completed. These test results indicated that she was too serious for their hospital to treat. They said her blood pressure was too high, her sugar was out of control, and she was anemic. The doctors felt that. the hospital didn't have adequate facilities if something should go wrong. They said she needed a major medical center like the U of M Hospital, where she had just been refused due to lack of medical insurance and funds.

Arlene's pain became so unbearable during the next couple of days that I had no choice but to take her to Hurley Hospital's Emergency room. While she was there they administered more tests. Again these were the same tests that the LCH and U of M Hospital had previously given Arlene. Her conditions was serious. In fact, within 3 days, Hurley Hospital removed Arlene's gall bladder.

From the moment Arlene's health problems became serious and we were spending money on doctors, hospitals, and medication, we began to worry about our financial situation. I needed some help from someone so I decided to go to the Lapeer County Department of Social Services. They advised us to withdraw the application because it would be denied for two reasons; we had excessive business assets and she was not considered totally disabled for 12 months. This meant it was useless even filling out an application because Arlene would not qualify for any financial or medical assistance. This was really a problem. I knew that I wouldn't be able to pay for these medical' bills or any others that would come to me. I work in construction and this type of work is pretty unpredictable. If there is no work, I don't get paid. Arlene's bills for medical expenses now totaled well over $8,000. We had many people contacting us about our outstanding bills. We even had Knollwood Clinic's accounting office where our family doctor practices send us a certified letter and tell us that they could no longer treat Arlene because we could not afford to pay them.

After the hospital removed Arlene's gall bladder, they were sure that her problems would disappear. Shortly thereafter, however, her eyesight began to fail. I took her to Lapeer Eye Clinic where they gave Arlene emergency laser treatments in an attempt to save her eyesight. They were unable to treat her eye problems and in turn referred her to Kresge Eye Institute in Detroit for more laser treatments and subsequent surgery for a detached retina. Also, they detected the first sign of kidney failure. We were told, however, that her condition was not critical and she would be released. Three days later, she was admitted to Mercy Hospital in Port Huron for stomach pains', nausea and vomiting. This time she was diagnosed with a Hiatal Hernia. She stayed in the hospital for 6 days. After Arlene was released, I spent the next couple of months driving her to the doctors. Arlene was very sick and needed to go to the doctors regularly. Since she could not go to our family doctor, I had to find another one. When I did it was far away from our home. I was having to take 1-2 days off per week from my job to drive 120 miles round trip to the doctors with Arlene. This was an expensive all day trip.

Arlene's kidney function was now at 45% so the doctors referred her to a kidney specialist in Port Huron. The kidney specialist couldn't do anything to help so he referred her to Wayne State University School of Medicine where she saw two more doctors. These doctors have informed us that her kidney function is down to 15%. They recommend that she prepare for dialysis. They believe that Arlene will be on dialysis before September. The surgeons who will install the tubes, scheduled Arlene for an appointment on the 21st of July. On the schedule it says payment in full on day of appointment. Once again, because we don't have insurance, if we can't pay the money up front, we can't get this important preparatory surgery.

I know we can't pay that money up front. We don't have that kind of money. Presently, we are being sued by two doctors and I have been subpoenaed to appear in court. Incidently, one of these doctors once said to me while he was examining Arlene, "my heart sure goes out to her." He felt very compassionate until he found out she couldn't afford treatments. Now he is suing us. Furthermore, I have $25,000 to pay in medical bills. Because I have lost so much time at work driving Arlene to the doctors, I can't even afford my house payments. The bank has threatened foreclosure.

I have tried to seek help through the various programs available. The Red Cross has been very limited, but of some help. The United Way, the Kidney Foundation and the Diabetic Foundation all can't get involved on an individual basis. I talked with the Lions Club, but never heard from them after my first call. I also went to the Social Security Office for assistance. Because Arlene has not worked 5 out of the last 10 years, she is not eligible to receive disability benefits. It's very frustrating to go to these agencies and ask for help but never receive anything from any of them.

It doesn't seem fair that we to have to experience this financial failure all because I refuse to quit working. As long as I continue to work, there is no help available. I believe that this clearly represents how are present system fails people like Arlene and me. If the U of M Hospital had helped Arlene from the beginning, I believe, she would not have lost her eye sight or be facing kidney failure today. It is really something when our present system only gives medical insurance to those who are completely impoverished or near death.

PREPARED STATEMENT OF CHERYL EICHLER

My name is Cheryl Eichler. I'm 28 years old and I have had Crohn's Disease for the past 12 years.

I was first diagnosed as having Crohn's Disease in November of 1976. I was 16 years old at the time. I went to the hospital in Dade City, Florida, because I was experiencing a lot of pain in my side and lower abdomen. I was having dizziness, fainting, and tired very easily. The doctors told me I was anemic and after many tests, diagnosed Crohn's.

My family then moved back to Michigan in March of 1977. I was admitted to Wayne County General with the Same Symptoms. I had my first surgery when they found it necessary to remove part of my colon. I was in the hospital a total of 3 months. Luckily, my mother was receiving assistance through the Aid to Dependent Children Program and because of this Medicaid we were able to survive my first battle with Crohn's.

I didn't have any problems until the middle of 1982. I had graduated from high school and found work at Manpower Services. Although I had no benefits, I was able to support myself. But soon I was in constant pain. My stomach had swollen so much that I couldn't even wear my clothes comfortably. I waited until the pain was so bad, about 6 months, before I went for any treatment. Why? Because I didn't have any health insurance and didn't know how I would pay for medical services. I was finally admitted to the hospital when an abscess began draining into my stomach. I could not eat or drink anything for 8 months. The drainage never stopped so in August of 1983 they took out more of my colon and performed an ileostomy. I was able to apply and receive Medicaid to help cover the costs of the treatment. Unfortunately, Medicaid only solved the immediate problem, and when I had recovered so that I could return to work, I was again without any type of medical insurance or assistance.

I found a job at 7-11 and was again able to meet my daily living expenses. Eventually, I was offered a salaried position and earned about $12,000 a year. But by October of 1985, I was again suffering the effects of Crohn's. I waited two weeks before going to the hospital because 7-11 offered no health insurance benefits.

By September 1986, I had developed peri-rectal abscesses. They are extremely painful and produce a great deal of drainage. But again, I didn't seek treatment until the end of 1987 or beginning of 1988 because I was very scared, had no insurance, and didn't know how I was going to pay for any more treatment.

Finally, in March of 1988 I had outpatient surgery for drainage of the abscesses. I set up a payment plan for this bill and am still making payments for the surgery. I also have added expenses for the care of equipment of my ileostomy. I was seeing the doctor approximately every 2 weeks. There was also the additional expense of my prescriptions.

On May 15, 1989, I was forced to resign my position at 7-11 in order to be admitted into the Westland Medical center. I was losing weight, was very run down, had a lot of pain, and the abscesses were draining heavily. I am still in the hospital. When I had my first surgery in 1977 my bill for 1 month of care amounted to about $20,000. Now after 1 month of hospitalization my bill is over $34,000. Twelve years ago I had my Mother's Medicaid to help pay for the bill. Today, I have nothing. I applied for Hill-Burton Funds from Westland Medical Center but was rejected because my $12,000 a year income was too great to qualify. I've applied for Medicaid as well but have been told that I do not meet the definition of disabled. They told me they would review the case further but that it could take and additional 45-60 days to reach a decision.

In the meantime, I am ready to be released but only if I can continue on my present IV treatment for the next three months. But without the promise that Medicaid will help pay for the treatment, the suppliers will not provide the equipment. One bag of hyperal for the IV costs over $100. I've used over 70 bags since I've been at Westland. Eventually, I will need more surgery to remove the rest of my colon. Without the surgery, there is a good risk that I would develop cancer. Until I can get some kind of aid, I will have to remain an inpatient at the hospital.

Even if, by some miracle, I'm granted Medicaid for this latest bill, that only solves the immediate problem. They don't know what causes Crohn's Disease; therefore, there are no cures. There are many people in my situation, and for us this is a lifelong illness.

Ahead of me lies the frightening task of finding another employer who will be sympathetic to my disease. Even if I'm lucky enough to find something, I'll be unable to find a job that will provide coverage for my treatment. Those of us with Crohn's could never work enough or make enough to pay for the long-term care that is involved with this disease. There is also the constant worrying and emotional stress of "How am I going to pay for these bills."

The treatment involved in battling this disease is extremely expensive. Someone like me who earns about $12,000 a year can never afford to pay for all of this. I think there is a definite need for help to the uninsured people in my situation and situations like it.

PREPARED STATEMENT OF J.W. ERWIN

Good morning, Senator Riegle. My name is J. W. Erwin. My son and I own a fruit and vegetable market called Erwin Farms on 10 Mile Road in Novi. Erwin Farms is our family orchard and has been in operation since 1922. I opened the retail store in 1963. My brother now runs the Orchard. I would like to thank you for holding a hearing in Michigan to listen to small business problems in providing health care coverage for employees.

I am here today to tell my story and also to represent the 22,500 small business owners in Michigan who are members of the National Federation of Independent Business. About 84 percent of NFIB's members in Michigan employ 19 people or less, fifty percent have 5 employees or less. Finding affordable health insurance is a major problem for us.

Our store employs 18 people, including five family members. We have a good record of employment and have not laid off any people in years. Our employees become members of our business family and it's important that we help them in any way possible.

Our Blue Cross/Blue Shield coverage last year increased $50 a quarter per employee for a total of $200 per employee. Our coverage is through the Farm Bureau, of which I am a member and have been for years. If I did not belong to the Farm Bureau, the insurance costs would be even higher due to the small size of our business. Because of the cost of health insurance, I am only providing coverage for four of my full-time employees. Without the help from the Farm Bureau, I probably wouldn't be able to afford coverage for anyone.

It costs me $764 for three months of health insurance on one employee, or about $3,056 per year, not including expected premium increases. In computing what it would cost me to cover part-time employees, I found that for an employee who works 17 hours, insurance coverage would cost $3.16 per hour. If the employee works 20 hours a week, the cost is $2.69 per hour. The cost for this coverage on a full-time employee breaks down to $1.35 per hour. Since my part-time employees earn between $4.50 and $7.00 an hour, providing insurance would be almost double my payroll costs for those employees.

Several years ago, through our local Chamber of Commerce, we were able to get less expensive group coverage. The insurance was cheaper, but the benefits were not as good, and we returned to Blue Cross/Blue Shield through the Farm Bureau. There aren't many choices for us, and on my own it's too expensive.

I believe that much of the increased costs are due to doctors scheduling far more tests for patients through fear of malpractice suits. These additional tests not only add to the cost of each claim, but require our employees to be away from the business for much longer periods of time. This, too, costs us money.

In closing, I would point out that my employees receive health care coverage tax free. I pay 100% of the premium costs. However, to me—the employer—it is *not* tax free. Seventy percent of the cost comes out of my pocket—out of my profit margin, which isn't great to begin with. Also, as the cost increases, the employee does not see this as a pay increase, but it really is. It does not act as a reward and does not increase productivity like a regular pay increase would.

Our retail store sells primarily perishable items. We are directly competing with big supermarket chains like the A&P and Kroger which are less than a mile from my place. Last year our net profit was $39,000. If insurance costs continue to rise and government continues to mandate benefits, we will reach a point where it will no longer be profitable for us to stay in business.

When health insurance costs keep going up, they are either paid by what would be profits in our business or by the customers when they come in to buy our fruits and vegetables. This is inflationary! Those types of costs can't be completely passed on to my customers if I want to keep those customers, nor can I get rid of enough jobs to absorb those costs without hurting my business. Big increases in insurance put me and my business in a no-win situation.

Please help small business owners in Michigan and the nation to find a solution to this costly and burdensome problem. Small business owners want to provide health care coverage. They care to keep good employees.

There is a perception that all small business owners have deep pockets and can afford these costs, as their profits are high. In the average company, employee compensation is six times greater than profits—six times as big. Seventy-percent of our national income is paid out in compensation to employees. That's 75 cents out of every dollar.

Prepared Statement of Rashi Fein

My name is Rashi Fein. I am Professor of the Economics of Medicine at the Harvard Medical School. I chair the Technical Committee of the Committee for National Insurance, which developed the Health Security Partnership National Health Plan, to which I shall refer.

I am extremely pleased to be here and to comment on the issue before this Committee. I have been doing research, teaching, and writing on issues in health economics since my first Federal Government employment as a staff economist on President Harry Truman's Commission on the Health Needs of the Nation in 1952, almost 40 years ago. I believe that we are closer today than ever before to enacting legislation to deal with the twin issues of universal insurance and cost containment. We are at the beginning of a process of serious discourse and debate.

You will note that I referred to two issues: the need to increase financial protection and access well as the need to contain costs and control expenditures. I am aware that the topic before us is somewhat narrower. It focuses on the specific needs of the uninsured and unemployed. But I believe that an effective *and sustainable* program for today's uninsured requires the development of a universal program hat covers all parts of our population and that, at the same time, addresses the problems caused by the continuing annual increases in health costs, prices and expenditures.

I shall not elaborate the data on he uninsured or on health care expenditures. You know those data and are reminded of them by your constituents, by individuals who are hurting because they lack access and by firms that each yea are forced to spend an increased amount for health insurance premiums.

But though I shall not detail these matters, it is important that we not ignore or forget the dimensions of the problems: there are almost 40 million Americans and this number has increased during the 1980's—who have no public or private health insurance protection. Furthermore, the annual increases in the costs of health insurance and in health care expenditures far exceed the annual growth in the Gross National Product and in the revenues and profits of individual firms.

America cannot continue on this course indefinitely. We are being driven in a direction which will require action—action to control and contain health expenditures lest we discover that the American economy, which already spends more on health care than does any other industrialized nation, can no longer compete effectively with other economies, lest we discover that rising health expenditures lead to declining profit margins and declining investment. We are also being driven to take action because the increase in the number of uninsured and underinsured will result in declining levels of health in our population and because the need to provide care even if the uninsured patient can't pay will contribute to the fragility of various health care institutions and to the coming apart of our health care system.

Both issues must be dealt with if we are to achieve a program that would be stable over any sustained period of time. Were we to enact a program that would provide universal insurance but which ignored costs, we would find that as costs escalated year after year we would be driven to cut back on the benefit package and on the coverage of the program. Similarly, were we to pass a cost containment program without assuring universal health coverage, we would find that expenditure containment goals would be met through reductions in quality and by denying care to some individuals.

Those factors led the Committee for National Health Insurance to appoint a group of individuals who, over a period of time, developed a universal health insurance program, rooted in equity and designed to deal with cost containment issues.

I would like to make one more point before describing the program that we have developed. That point is that, important as it is to address the problems of individual population groups most in need of care—the unemployed, the poor, patients with AIDS, young children, pregnant women, and so forth—the fact is that programs that address specific beneficiary groups are difficult to administer because they require sorting people with changing demographic and economic characteristics—today you're unemployed, tomorrow you have a job—and are difficult to sustain over long periods of time—their support waxes and wanes. Our universal social security system has fared better than our welfare systems; Medicare, which covers everyone, has fared better than has Medicaid. All of us can and should support programs that are designed to assist those who need help, including the unemployed. But we know that that assistance would be more effective and would last much longer if special programs were replaced by universal programs in which, for example, the fate of the unemployed was inexorably intertwined with the fate of the employed; in which the fate of the poor were inexorably intertwined with the fate of the rich and of the middle classes.

Let me turn to a description of the *Health Security Partnership*. I shall do so by very briefly describing some of its important characteristics and how it is designed to achieve its various goals.

(1) It is a universal program that provides comprehensive insurance benefits, funded in an equitable manner.

(2) It is based on a partnership between the various levels of government. Specific tasks and responsibilities are assigned to the Federal Government and the various states.

(3) It provides for uniform benefits across the land, but permits inter-state choices and variation in the ways in which the individual states enroll their residents, administer their programs, and finance benefits. These differences would reflect the preferences of the people served by the various programs.

(4) It supports effective cost-containment by requiring the development of state health budgets and by creating a system designed to lead to informed discussion debate, budget choices, and trade-offs.

(5) It has built-in quality-enhancing measures, including effective and comprehensive technology assessment and evaluation of the effectiveness of various clinic interventions and laboratory procedures.

Let me amplify some of the points have made.

The Health Security Partnership program is built on a partnership between Federal and state levels of government. That partnership represents a welcome and necessary departure from earlier designs. Previous national health insurance programs looked to the Federal Government to enroll, finance, and administer the program. In contrast, our program looks to the states to enroll the population that would be covered (and that includes all residents of the individual state) and to administer the cost control and quality assurance efforts for the program that each of them will be operating.

We look to the states because the level of competence in many of our states has risen significantly in the last decade and because we believe the quality of decisions about trade-offs—such matters, for example, as the trade off between convenience and expenditure—will be enhanced by having those decisions made closer to the people who are affected. Health care is a local service and the new heterogeneity of health care systems tells us that no single pattern of organization should or can be mandated from the nation's capital. We believe that the states are the nation's laboratories and should be encouraged to experiment.

Nevertheless, though we believe that states can measure up to their responsibility in administering the health programs within their borders. We are aware that some states will need financial and other assistance to develop and operate effective, comprehensive and universal health insurance programs. We therefore look to the Federal Government to do a number of things: to set the groundwork and rule for the experiments by mandating a comprehensive list of benefits that all states would have to provide—this, in order to ensure portability of benefits across state lines and to prevent competition between the states in and around the benefit package; to make financial resources available to the individual states—financial resources that take account of state needs and state capacities to fund such programs; to require that individual states develop effective cost containment and quality insurance programs. We would require the Federal Government to develop a budget for health care and we would require that each individual state similarly develop a budget for the services that would be covered under the health insurance program. We believe that only as states, the private sector, and the Federal Government operate within budgets will costs be constrained.

Even so, more than budgets are required and our program addressed issues in the payment of physicians and of institutional costs. We suggest a number of specific measures in the area of prospective budgeting, fee schedules, expenditure targets and claims review that would enable payment for services to be contained within reasonable and responsible limits.

We have designed a comprehensive benefit package that would provide financial access to both physician and institutional services. Furthermore, we have included the first phase of a program for long term care. It is worth commenting on the fact that we have modest cost-sharing in our program. I do not think that the members of the committee that developed this program believe that there is some inherent virtue in having deductibles or co-insurance payments by individuals. We would prefer to have a program that eliminated such cost-sharing. That can be done and, indeed, has been done in Canada. Nevertheless, we recognize that, at this time, the resources of government are strained and that there are and will be pressures to reduce the premium or tax costs that would have to be passed on to employers or to government.

The levels of cost-sharing that would be required under our program are modest and we protect individuals against excessive cost-sharing by providing an upper limit to the amount that any individual or family would have to pay on an out-of-pocket basis. I also want to stress that we have designed special provision to eliminate all patient payments by individuals and families below the poverty line and by persons with incomes up to 150% of poverty for pre-natal and well baby care. Furthermore, we have proposed that there be no "balance billing." If individual states or the Federal Government desire to operate a program with even less cost-sharing, we would have no objection. We do not believe that deductibles and co-insurance "build character" or are a necessary part of the therapeutic regimen.

While recognizing that individual states may enroll their residents in whatever manner they choose, I think it is useful to describe two alternatives. There may some states that will want to adopt a Canadian-like system in which all of the residents would be enrolled in a single financing program—though of course receiving their care from individual and different delivery systems. Such a program might be operated by the state, with or without the assistance of insurance companies or fiscal intermediaries. It could be paid for through taxes or premiums but clearly would involve a major transfer of financial responsibility from the private sector of state government. This, I should point out, is in fact the way the various provincial health insurance programs in Canada have chosen to operate.

The second alternative, the one I suspect most states would opt for, is administratively more complex and is therefore not likely to bring all the savings in administrative expenditures that the Canadians have experienced. It nevertheless has substantial appeal in the American context, largely because it extends and builds upon programs that a ready exist.

Under this approach, employers would be required to provide or offer financial support for the provision of health insurance for their employees. This approach is workable if adequate provision is made to protect those employers whose profit margins are very low and those employees who work only part time or at low wages.

In either case, of course, all residents of a state—including the unemployed—would be enrolled in a health insurance plan. In the first case this would occur because all persons would be part of a single financing program. In the second case, because state government would assume the responsibility for individuals who did not receive insurance through their employer.

In order to prevent employment discrimination and unhealthy competition among employers in and around risk selection, the private/state insurance program would be based upon community rather than experience-rated premiums. I can describe the mechanism in three sentences.

(1) All employers would make a payment based on a community promulgated rate to a central agency operated by or under the supervision of the state.

(2) Each employee would have the right to choose his or her deliverer of care and to select an insurance company who would administer benefits and claims associated with that employee.

(3) The agency that has collected all the funds would transmit the appropriate premium to the insurance company or (as in the case of an HMO) the deliverer of care that the covered person has selected.

That approach, we feel, would make it possible to provide for equitable financing and for effective cost containment. It would encourage competition around efficiency in the delivery of care and administration of benefit and claims review programs while discouraging competition around how to get healthy subscribers into your group while passing off potential high risks to someone else.

There are many other features of the program that I could discuss, including of course its quality enhancement provisions. The limits of this statement prevent my doing so. I do, however, want to take the time to emphasize that I believe we are at a turning point in the history of health insurance programs designed to achieve the goals that we have discussed today.

This is the case because the American business community, shocked by the high annual increases in health care costs, aware that other nations (including Canada) appear to be getting more value for their health care dollars, increasingly cognizant of the competitive disadvantage under which it operates, is now willing to engage in discussion and debate about measures which it once rejected. I do not imply that here is unanimity within the business community or even that some "favorite" approach has emerged. But one can discern a desire to solve the problems that I have discussed, a willingness to engage in serious debate and consideration of alternative approaches.

I believe it is time for that kind of public debate to take place. I believe that many individual and organizations in the private sector, and many state legislators and governors, look forward to a discussion of these matter There is renewed interest in doing something about the financing of American health care. I would hope that the executive and legislative branches of the Federal Government would participate in and help provide some structure and some leadership for the discussions that in due course will lead to action.

PREPARED STATEMENT OF WILLIAM S. HOFFMAN

Mr. Chairman, my name is William Hoffman. I am Director of the Social Security Department of the International Union, UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on the very important issue of health care for the uninsured. The UAW commends you, Mr. Chairman, for your leadership in addressing one of the most serious social problems facing this nation: The lack of health insurance coverage for millions of Americans and their families.

THE PROBLEM

A substantial portion of the population lacks access to even minimal health care services. Today, 37 million Americans, approximate 16 percent of the population, lack public or private health insurance coverage. Twenty-seven percent of the population—more than one person in four—is without health care coverage for at least part of the year.

Significantly, about three-quarters of the persons without health insurance coverage are working men and women and their dependents. Although the majority of employers provide their employees with health care protection, a growing number of employers do not offer any health insurance coverage.

In addition to the decline in employer-sponsored health coverage, there have been substantial cutbacks in the Medicaid program. Presently, those with family income below the Federal poverty standard may not qualify for Medicaid benefits if they are not in families with dependent children, disabled or otherwise categorically eligible for Medicaid. In 1984, the median level of qualifying income for Medicaid benefits was 48 percent of the Federal poverty level. Only 42 percent of the nonelderly population living in poverty qualified for Medicaid (EBRI Issue Brief, May 1987).

The UAW is deeply concerned about the erosion of the Medicaid program and the impact it is having on the health status of this nation's children. In 1986, Medicaid served 200,000 fewer children than in 1978 when there were nearly 25 percent fewer poor children. Medicaid now serves less than half of all poor children annually. Thirty-two percent, or 11 million, of those without basic health care coverage are children.

Black Americans and other racial minorities continue to experience markedly higher rates of death and disease than whites. The infant mortality rate in this nation is one of the highest of all industrial nations and the death rate among nonwhite babies in the United States is 70 percent greater than for whites.

Today, there are not enough doctors in rural areas and inner city neighborhoods. At the same time, dollars are wasted on excess hospital beds and duplication of expensive "state-of-the-art" equipment, while more doctors than are needed work as highly paid specialists in affluent suburban areas.

These problems raise serious questions about the lack of financial and geographic accessibility to health care services in this nation. It is simply unacceptable for a nation that has consistently been a world leader in advancing modern medicine to allow so many people to be denied access to adequate health care services. Too often individuals are forced to postpone or do without needed medical care because limited family income must be used for food, housing, or other basic needs. In addition, the lack of health insurance coverage ultimately increases total health expenditures because individuals are forced to rely on hospitals (particularly public hospital emergency rooms) for medical treatment, instead of using preventive and other types of more cost-effective medical services.

Many of the problems we currently face in providing health care for the uninsured have been aggravated by the increasing corporatization of medicine and the Reagan Administration's approach of promoting growth of the for-profit sector in health care. Public hospitals and not-for-profit community hospitals traditionally have provided a significant measure of charitable care for the uninsured. A recent study in the New England Journal of Medicine which examined the differences in uncompensated care among hospitals in five states found that in four of the states, the amount of unreimbursed care provided by public and not-for-profit hospitals 1984 and 1985 was 50 percent to more than 100 percent greater than the unreimbursed care provided by for-profit hospitals. Thus, the growing number of for-profit hospital chains has severely reduced social subsidies for the poor and uninsured. As a result, many individuals who are not able to pay for care must live in fear of serious illness or accident.

At the present time, uninsured persons usually wind up being treated as uncompensated care by hospitals and other health care providers. The cost of providing this "uncompensated" care, which is estimated to be about $8 billion (EBRI Issue Brief, May, 1987), is not fully absorbed by hospitals and other providers. Instead, it is passed on to other private payers, mostly to unions and employers, who are providing health care protection.

The UAW has also been concerned about situations where a worker does not receive any health insurance coverage from his or her own employer, but instead is covered by a spouse's employer-sponsored health insurance. In such cases, the health care costs associated with the worker are directly shifted from one employer to the other. This type of cross-subsidization between employers is unfair and inefficient. Employers should not be allowed to shift the cost of providing basic health protection for their employees to other businesses.

The skyrocketing cost of health care has adversely affected the international competitiveness of businesses and has threatened job security for millions of Americans. For example, in Canada, health care costs for employers are approximately one half of the costs in the United States. This provides an incentive for multinational corporations to transfer more production and plant investment outside this country.

THE SOLUTION

Mr. Chairman, such an array of difficult and interrelated problems can be addressed only by the enactment of a universal and comprehensive national health insurance plan. Every industrialized nation, with the exception of the United States and South Africa, has found it politically, economically and socially practical to adopt a national health security program. Individuals in Canada, Great Britain, Sweden, West Germany, Italy and other countries are guaranteed basic health protection by law. American citizens should also have this same protection by law as a basic social right.

The UAW has been a leader in the fight for a national health insurance program. We remain committed to this goal, and are confident that it will be achieved.

The UAW has represented workers in Canada for many years, and our experience with their national health care program has been very positive. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost-effective manner. Whereas the United States currently devotes over 11 percent of its Gross National Product to health care, Canada only spends about 8.5 percent of its Gross national Product on health care.

Drawing from the Canadian experience, the Committee for National Health Insurance (CNHI) has developed a proposal entitled the "Health Security Partnership," which would provide comprehensive health insurance benefits to all Americans, and also institute effective cost containment and quality assurance measures. This program would have Federal standards, but would be administered and implemented by the states. The UAW strongly supports the Health Security Partnership proposal, and urges Congress to give it serious consideration as a solution to the health care problems facing this country.

The UAW also applauds the landmark legislation which was enacted in Massachusetts last year to provide universal access to health care insurance for all residents of the state. Under this legislation, most employers will be required to provide or pay for the costs of health insurance coverage for their workers and their families. In addition, a state fund will provide health insurance to individuals not covered under employer-sponsored health plans, including the unemployed and certain functionally impaired individuals who are without health care coverage. The UAW urges similar action in other states. Ultimately, however, we believe such a program needs to be implemented on a national level.

Senator Kennedy and Representative Waxman have introduced the proposed Basic Health Benefits for All Americans Act of 1989 (S. 768; H.R. 1845). This legislation would require all employers, as a condition of doing business, to provide their workers and their families with at least a minimum level of health insurance benefits. In addition, the legislation would gradually phase in a public program to provide health insurance coverage to persons who are not attached to the workforce.

Similarly, in the last Congress Representative Stark introduced the proposed Employee Health Benefits Improvement Act of 1988 (H.R. 4951). This legislation would have imposed an excise tax on any employer that fails to provide a minimum level of health insurance benefits to their workers and their families.

The UAW strongly supports the basic thrust of these hills. Regardless of the enforcement mechanism (Fair Labor Standards Act, Public Health Act, or Tax Code) we believe that all employers should be required either to provide a minimum level of health insurance benefits directly to their employees and their families, or to pay a tax to the government to cover the cost or providing these health insurance benefits through a government sponsored program.

This legislation would accomplish two important objectives. First, and most importantly, it would significantly improve access to needed health services and thus improve the health of millions of Americans.

Second, this legislation would substantially reduce the unnecessary, inefficient, and unfair cost-shifting that takes place in our present health care system. This would result in substantial savings for the Federal Government and to the majority of employers who currently provide health care protection.

To accomplish the twin objectives of expanding access to health care and reducing unfair cost-shifting, the UAW believes it is essential that three basic elements be retained in any legislation:

- *All* employers must be required to provide or pay for a minimum package of health insurance benefits for their workers;
- *All* workers (including part-time employees working 17.5 hours or more per week) must be covered under the minimum package of health insurance benefits; and

- The minimum package of health insurance benefits must also provide coverage for spouses and dependent children.

The UAW also supports a number of other provisions in these bills. In particular, we strongly support the provisions that would pre-empt all State laws requiring health insurance plans to offer specific benefits or to include particular types of health care providers. The UAW applauds the provisions prohibiting denial of benefits for pre-existing conditions. And we commend the sponsors of the legislation for including provisions which would allow small businesses to obtain coverage at more affordable costs.

The UAW recognizes that some elements of these bills will require further refinement. But we believe that their basic approach is sound. The UAW urges this Committee to give serious consideration to the approach embodied in these bills as a way of dealing with the difficult problems associated with providing health care for the uninsured.

Some persons may criticize these bills as being "anti-business." That is simply not true. The overwhelming majority of employers who currently offer health insurance benefits to their workers will *not* have to shoulder any additional burdens under the bills. In fact, they will enjoy significant cost saving by virtue of the reduction in cost-shifting among employers, the preemption of state mandated benefit laws, and the establishment of regional or state pools that will be able to offer insurance coverage at more affordable rates.

Some opponents of these bills have objected to the notion of the Federal Government "mandating" employee benefits. But clear there is ample precedent for the Federal Government to take such action. Our society has already mandated that employers provide or pay for a minimum wage, contribute to minimum retirement income, disability insurance and basic protection against loss of income due to layoffs (through Social Security and Unemployment Insurance). We have also imposed minimum occupational health and safety and pension funding standards on employers. In line with these precedents, it is now time for the Federal Government to mandate all employers to provide or pay for a minimum level of health insurance protection for workers and their families.

I would like to emphasize, Mr. Chairman, that the approach incorporated in these bills builds upon a private sector solution. The bill basically seek to require the private sector to step up to the responsibility of providing adequate health insurance protection to workers and their families. There is no justification for letting employers escape from this fundamental responsibility. To allow a small minority of employers to continue to evade this responsibility is unfair to Federal Government, to other employers, as well as to workers and their families.

The Health Insurance Association of America has developed a proposal which would attempt to expand access to health insurance through a "voluntary" private sector approach. This proposal is an attempt to encourage employers to offer health insurance benefits through a combination of tax and other incentives (such as exempting basic, low cost health insurance plans offered by insurers from state mandated benefit laws). This approach is doomed to failure. Under any "voluntary" system, a substantial number of employers will always decide not to offer any health insurance coverage. No matter what incentives are offered, it will always be cheaper for employers not to offer any benefits. Thus, a substantial number of workers and their families will still be without access to health insurance benefits, and the health care costs associated with these individuals will still be shifted unfairly onto the Federal Government and other employers.

In addition to the minimum health benefits legislation, the UAW also strongly supports the expansion of Medicaid coverage to include all persons living in households with incomes below the Federal poverty level. The states should not be allowed to apply different criteria in determining eligibility and the types of services provided to persons below the poverty level. The United States general Accounting Office (GAO) reported that between 1980 and 1986, out-of-pocket medical costs have increased substantially for the poor. This has been largely a result of Medicaid cutbacks. It is unconscionable to permit the states to exclude so many impoverished women, infants, and elderly people from eligibility for Medicaid benefits.

Finally, recognition of the serious plight of the uninsured has led to a number of voluntary efforts on the part of community leaders, labor unions, and provider groups around the country to provide some health care services for the uninsured. There have also been a number of initiatives at the state level to increase accessibility to health care for those unable to purchase adequate health insurance coverage. Fifteen states have established state comprehensive health insurance associations, sometimes referred to as-risk sharing pools. These state subsidized health insurance pools offer an alternative for persons unable to purchase coverage from other sources.

The UAW commends those states that have established risk pools and encourages all states to take such action. Such pools should cover the unemployed, so-called "uninsurables," and retirees of bankrupt companies who have lost their health insurance coverage. However, a coordinated national health program would be a more effective means of providing coverage to these groups of the uninsured.

The UAW is committed to making quality health care services available to those who have traditionally been excluded: the impoverished, the unemployed, racial minorities and the functionally impaired. As a nation we must begin to address these significant concerns. Every day we delay makes the task that much greater.

Positive approaches are needed that will effectively address the fundamental issues of access to quality health care services. Approaches are needed that:

- address unmet health care needs;
- expand coverage;
- remove harriers to access;
- promote quality;
- remove discrimination;
- rehumanize the health care system to put peoples' needs first;
- reign in costs and budget appropriately.

Mr. Chairman, a national health insurance program will ultimately be needed to address the many vexing problems of the health care system. It is not too late for the United States to join the rest of the modern world in providing universal health care protection.

Mr. Chairman, the UAW applauds the leadership that you have provided in efforts to make our health care system more equitable and effective. We appreciate the opportunity to present our views on the problems associated with providing health care for the uninsured. Thank you.

Prepared Statement of Senator Edward M. Kennedy

Mr. Chairman, I am delighted to have this opportunity to appear today before the Subcommittee on Health for Families and the Uninsured of the Senate Finance Committee. I speak for all of us on both sides of the aisle in the Senate Labor Committee when I say that we look forward to working closely with you to make the right to health care a reality for all Americans. I am hopeful that we can achieve this historic goal before the 101st Congress is history.

The time has come for action, because we face a growing crisis in access to health care. Thirty-seven million Americans have no health insurance coverage, either public or private. Sixty million more have insurance that even the Reagan Administration agreed was inadequate. Every year, fifteen million Americans seek health care and are turned away or neglect their health because they cannot afford the care they know they need. Every year, almost two and a half million American families face catastrophic out-of pocket costs in excess of $3,000 that insurance does not cover.

These conditions should be intolerable in twentieth century America. No other country in the world except South Africa tolerates a system in which the state of a family's health is determined by the size of a family's wealth.

I hope to be able to convince this Committee that one aspect of the solution should be the Basic Health Benefits for All Americans Act which was reported favorably by the Labor Committee in the last Congress and is pending once again in our Committee in this Congress. The basic outlines of this approach have just been endorsed by two major national commissions—the National Leadership Commission on Health Care whose honorary co-chairmen were President Ford and President Carter, and a Ford Foundation commission chaired by Irving S. Shapiro. In fact, this bill is very similar to legislation originally proposed by the Nixon Administration and introduced by Senator Packwood.

The measure is built on two basic concepts. First, the job-based system of health insurance that provides coverage for most workers and their families should be extended to the millions of other workers who do not have access to it today because their employers don't provide it. This simple step will provide coverage for 23 million people—two-thirds of the uninsured.

Second, Medicaid should be expanded to provide benefits for those not covered by the current program and not eligible for job-based insurance. Because of budget pressures, the public program could be phased in gradually, beginning with the 6 million uninsured Americans who are poor. Eventually, all uninsured citizens not eligible for job-based insurance should have access to coverage through this expanded public program.

The details of the coverage provided by the private and public program are included in materials attached to my statement, but several key principles should be explained. First, the benefit package that businesses would be required to provide is generally consistent with the benefits most businesses already provide voluntarily to their workers. This is not ideal coverage, but it is basic coverage. Our goal is not to micro-manage every health benefit plan in the country. What we should do, however, is to guarantee coverage where none is currently available, and to upgrade coverage where it is grossly substandard.

Second, the plan includes an actuarial equivalency test to provide flexibility to employers. Businesses would not be permitted to drop the basic required benefits, but they could alter other aspects of their coverage to meet the particular needs of their work force, so long as they provide coverage which, in total, is as good or better than the basic plan. A recent study by the respected consulting firm, Hewitt Associates, found that 95 per cent of the firms surveyed offered benefits that were actuarially equivalent to or better than the required plan.

Third, the plan provides for both basic and catastrophic coverage. Neither is sufficient alone. All families need catastrophic protection, so that they will not be financially devastated by serious illness. But all families, particularly low income families, need basic protection as well. With only catastrophic coverage, many families would never get the primary care they need to avoid catastrophic illnesses in the future.

Fourth, the plan prohibits exclusions because of pre-existing conditions and artificial limits on the scope and duration of benefits. Such exclusions and limits make a mockery of the concept of health insurance protection.

Fifth, the plan reforms current small business insurance by establishing private, competing insurance pools to bring the benefits of guaranteed availability, community rating, and economies of scale to small businesses. These reforms are accompanied by an additional protection: a subsidy for small businesses for which the cost of health insurance is excessive.

In the course of these hearings, the committee will undoubtedly hear from witnesses who claim they oppose this measure because of their concern for small business. The fact is that the current small business insurance market is a disaster area. Costs are far higher than large businesses pay for comparable coverage; insurance is often unobtainable at any price; exclusions for pre-existing conditions are almost universal; and no small businesses can be sure that the coverage available today will not be withdrawn tomorrow. These problems demand correction—and this legislation will provide the relief that small businesses need.

Finally, this approach keeps the solution to this problem in the private sector to the maximum extent possible. The American taxpayer is not asked to assume a single dollar of costs that can be the responsibility of private employers, the private insurance industry, and American workers.

As a practical matter, there are few realistic alternatives. We could try to enact a national health insurance program, as most other industrial nations have done. I have been an advocate of that approach in the past—and that may be the ultimate destination of the U.S. health care system. But the uninsured have already waited long enough. Their right to health care should not be held hostage to the long task of building a political consensus around a radical change in the current system.

A second alternative is to place the major burden for a solution to this problem on the taxpayer, by proposing the massive and costly expansions of Medicaid that would be required to help the tens of millions of Americans who are uninsured. At least for the foreseeable future, it is unlikely that the Federal budget could stand that burden.

Even if we restrict Medicaid expansion only to poor Americans, we would already be beyond what we can probably afford in this time of tight budgets. Six million of the uninsured are not members of working families, and they would be covered under the public part of my proposal. An additional five million uninsured Americans who are working would be covered by their employer. If we try to cover them all under Medicaid, the taxpayer would have to bear the cost for 11 million citizens instead of six million.

Even that is not the end of the story. Nearly 4 million poor Americans are workers and now have employer-based coverage. If Medicaid were available to all of them, employers would begin to drop their own coverage, and Medicaid would have to cover nearly 15 million people, two and one half times as high as with the alternative that I favor.

Medicaid is part of the answer to this problem—but it can hardly be an effective answer unless employers are also asked to do their part.

Two years ago, there was little attention to the crisis in access to health care. Today, scarcely a month goes by without a new study recommending far-reaching solutions to this problem.

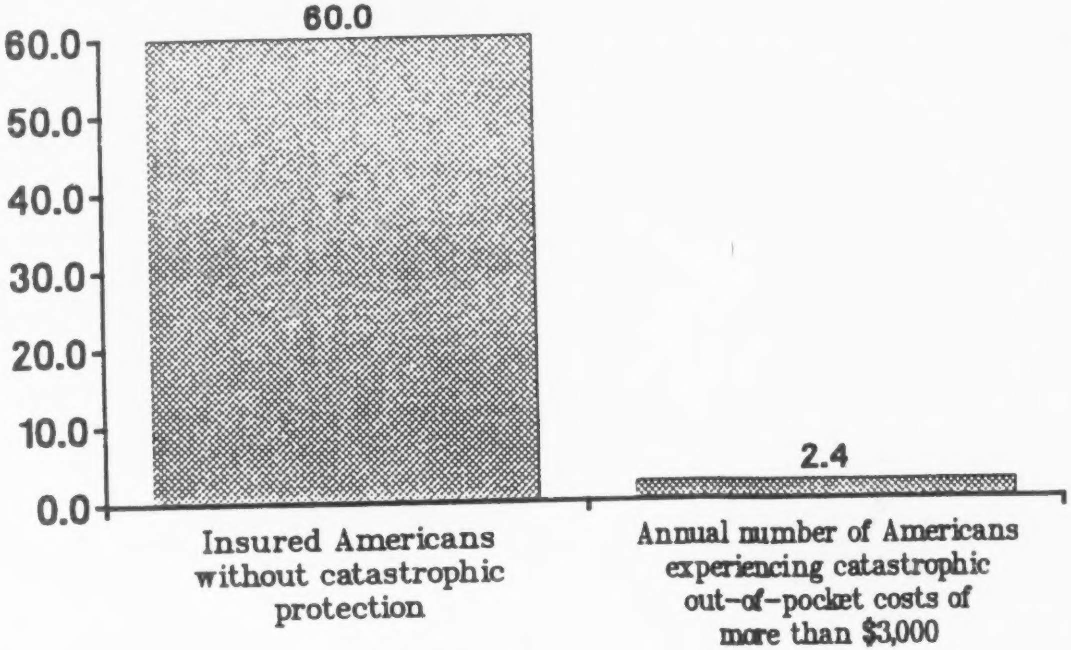
Two years ago, few groups were willing to lend their name to the Basic Health Benefits legislation; for those who did, support was lukewarm at best. Today, more than 150 groups from all parts of society have indicated a willingness to work to enact this idea into law.

According to polls I have seen, support is strong for this idea among citizens of all income levels, all races, all regions of the country, and among liberals and conservatives alike.

The health care system we have today is a national disgrace. For more than a decade, I have called it the fastest-growing failing business in the nation. Can't we finally agree that in America in 1989, health care should be a basic right for all, not just an expensive privilege for the few?

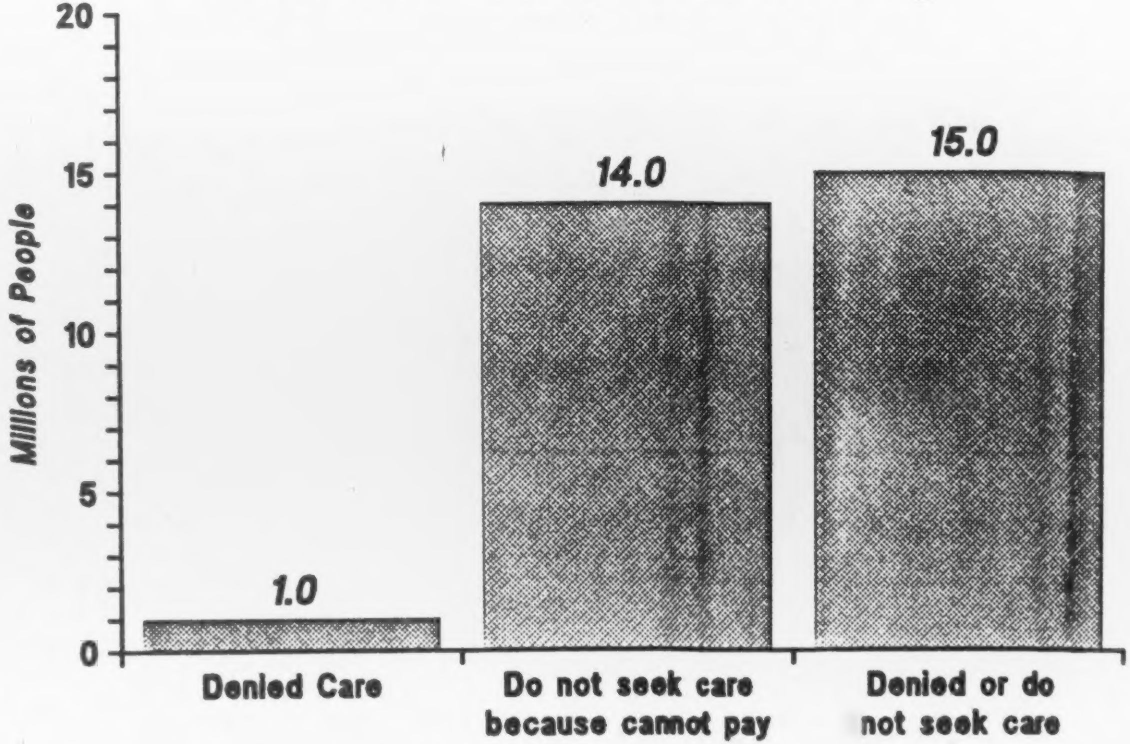
Attachment.

Millions of Americans are Vulnerable to Catastrophic Costs



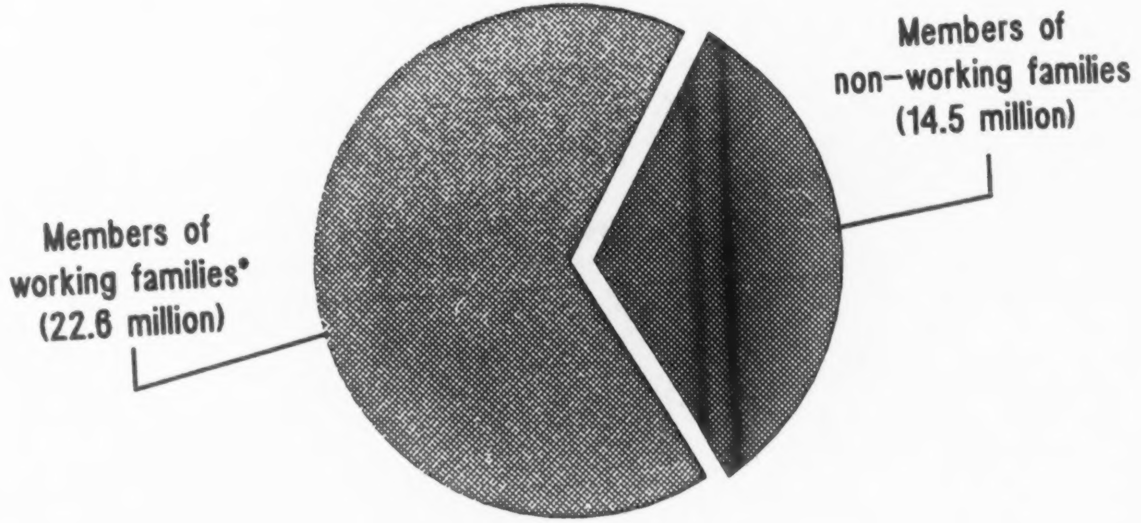
SOURCE: Department of Health and Human Services. "Insuring Catastrophic Illness for the General Population." 1987

Americans Lack Access To Care Because They Cannot Pay



Source: Robert Wood Johnson Foundation Survey, "Americans Report on Their Health Care." 1986

WHO ARE THE UNINSURED?



*Number of uninsured where household head works 17 1/2 hours/week or more

SOURCE: U.S. Census Bureau, Current Population Survey, March 1987

Summary of Proposal

Universal Coverage by the Year 2000

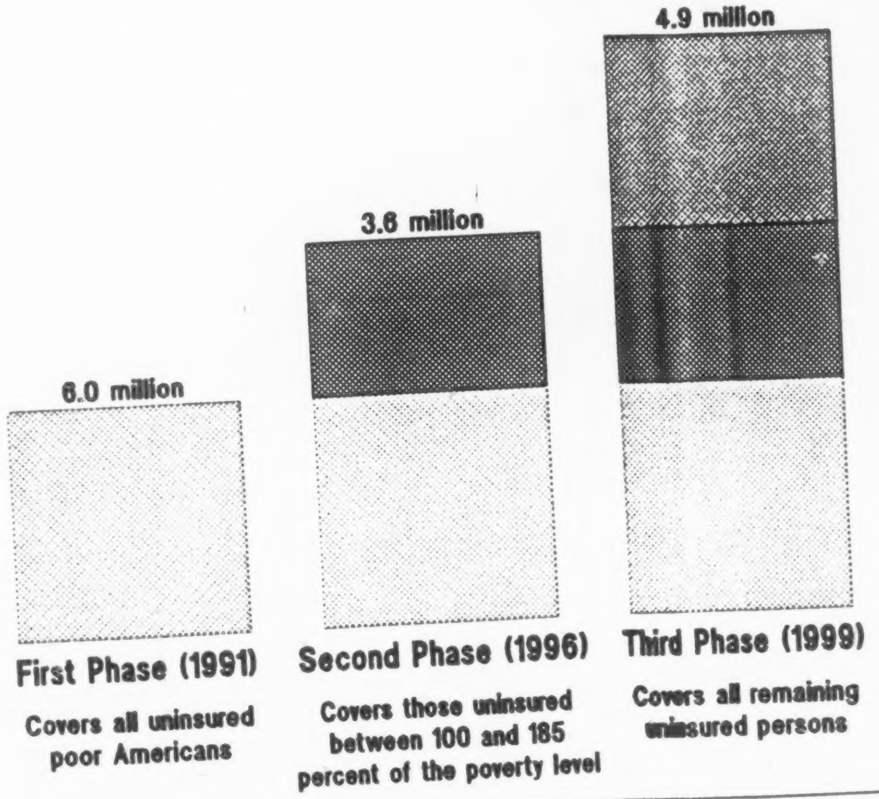
-- Mandate requires all employers to provide health insurance meeting minimum standards to all workers and dependents

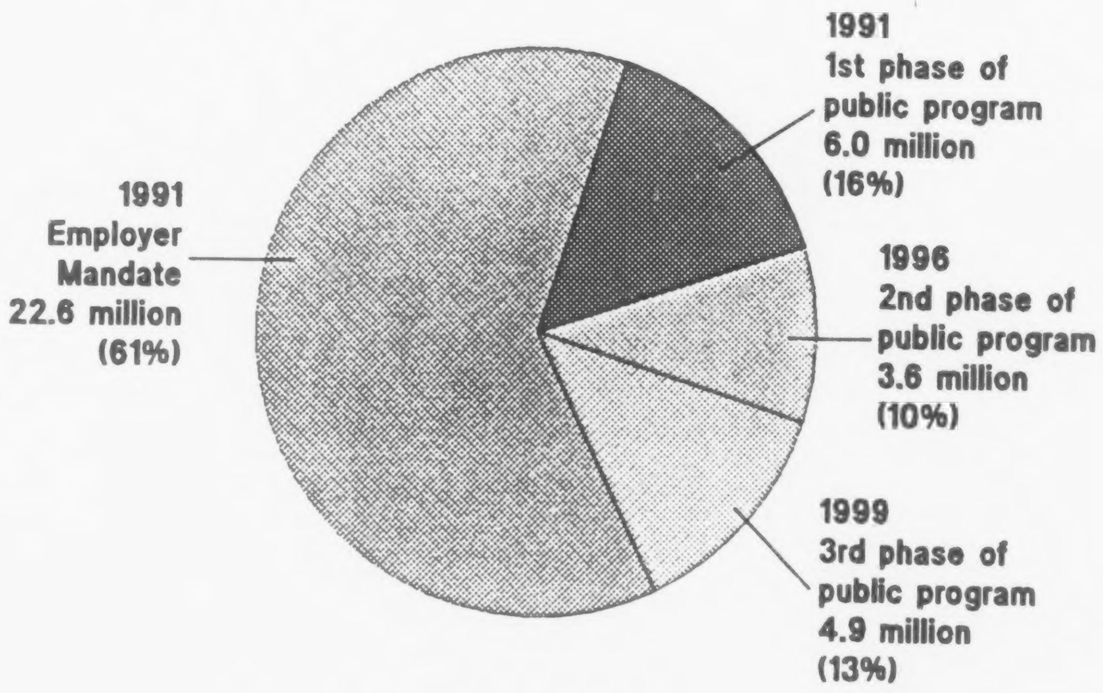
-- Phased-in Federal-State public program provides coverage for the remaining uninsured

EMPLOYER MANDATE

- Employers required to provide basic package of health benefits to all full-time employees and dependents of these employees (23 million people)
  - Basic package to include:
    - physician services
    - hospital services
    - diagnostic tests
    - prenatal/well baby care
    - limited mental heath coverage
    - catastrophic coverage ($3,000 out-of-pocket limit)
  - Maximum limits on deductibles, co-payments, and employee share of premium
  - No exclusion from coverage based on health status or preexisting conditions
  - Actuarial equivalency test allows flexibility in benefit design
- Regional Insurer Program provides community-rated insurance coverage for currently uninsured and small businesses
- Small Business Subsidy for those businesses for whom the cost of compliance with the requirements of BHB is excessive

PUBLIC PLAN


6.0 million
3.6 million
4.9 million
First Phase (1991)
Covers all uninsured poor Americans
Second Phase (1996)
Covers those uninsured between 100 and 185 percent of the poverty level
Third Phase (1999)
Covers all remaining uninsured persons



ALL AMERICANS ASSURED ACCESS TO HEALTH CARE COVERAGE BY THE YEAR 2000

THE SMALL BUSINESS INSURANCE MARKET-A COLLAPSING SYSTEM

-- Excessive Cost

  * Business of 25 or fewer employees pay 20 percent more than large businesses for comparable coverage.

  * Business with 10 or fewer employees pay as much as 35 percent more.

-- Pre-existing condition exclusions deny coverage for illnesses that pose the greatest risk.

-- Firms and individuals within firms denied coverage based on health status.

-- Insured firms face withdrawal of coverage or massive price increases in the event of serious illness within the group.

BHB GUARANTEES AFFORDABLE COVERAGE TO SMALL BUSINESSES

-- Access to coverage guaranteed

-- Exclusion of pre-existing conditions prohibited

-- Community-rating guarantees a fair, average price, regardless of health status

-- Regional insurers assure economies of scale, reductions in administrative costs, access to managed care systems: total price reduction -- 25%

-- Allows new, small businesses to purchase low-cost coverage during their start-up period

-- Requirements phased in for smallest businesses

-- Provides financial protection for small businesses for whom cost of compliance with the bill is excessive

CHILDREN AND DISABLED BENEFIT FROM BHB

Children

-- 12 million uninsured children gain coverage (9.8 million/82% covered in first phase)

-- Prenatal and well-baby care for all pregnant women and infants, including 600,000 uninsured deliveries annually

-- Coverage for 16,500 uninsured, high cost, very low birthweight infants annually

Disabled

-- Elimination of pre-existing condition exclusions

-- Guaranteed coverage for 3.2 million uninsured, disabled adults

-- Coverage for 426,000 disabled children

-- Protection from insurance loss for seven million insured but medically uninsurable people

ALTERNATE SOLUTIONS

European/Canadian-style national health insurance

Expand Medicaid

Basic Health Benefits:

- employers responsible for health care coverage for workers and their families
- public program responsibility for remaining uninsured

EUROPEAN/CANADIAN NATIONAL HEALTH INSURANCE

Some theoretical advantages

Guarantees basic human right to health care

Radical shift in current system

- changes relationship of providers to payers
- more central control of health care system
- shifts payment burden

Lengthy process to build consensus

Thirty-seven million uninsured Americans should not have to wait

EXPAND MEDICAID/NO REQUIREMENTS FOR EMPLOYERS

-- Excessive cost to the taxpayer
  - o Number of uninsured poor required to be covered under Medicaid increases from 5.9 million uninsured non-workers to 10.9 million uninsured non-workers plus uninsured workers
  - o If employers drop coverage, number of poor to be covered increases to 14.7 million (uninsured non-workers plus uninsured workers plus currently insured workers)
  - o Number of uninsured poor and near poor (less than 150% of poverty) required to be covered increases from 8.4 million to 24.7 million

-- Won't solve the problem
  - o Seventy-five percent of uninsured workers and dependents are not poor
  - o Sixty-one percent are not near poor

-- Would undermine private employment-based insurance system

BASIC HEALTH BENEFITS

- Builds on current system
- Burden shared by employers / employers / taxpayers
- Promotes equity between employers
- Guarantees every American basic human right to health care

SENATOR EDWARD M. KENNEDY'S PROPOSED BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT (BHB)

THE PROBLEM

Rising number of uninsured Americans

Thirty-seven million Americans currently have no health insurance coverage -- and the number has been rising by almost a million a year since 1980. Approximately two-thirds of the uninsured (23 million) are members of families in which at least one member of the household works full-time. Children constitute one third of the uninsured (12 million children).

Inadequate insurance leaves millions vulnerable to catastrophic costs

Sixty million Americans have some insurance but they are underinsured. They have no catastrophic cap on their vulnerability to out-of-pocket health care costs and are potentially at risk in the event of serious illness.

Denial of essential care/Families unprotected against high costs

A recent report by the Robert Wood Johnson Foundation found that one million Americans annually are denied health care because they cannot pay for it; an additional fourteen million do not even seek care they feel they need because they know that they cannot afford it. A recent study found that up to one-third of hospital admissions could have been avoided by earlier access to care. According to the Department of Health and Human Services, about two-and-a-half million families annually face catastrophic, out-of-pocket health care expenses exceeding $3,000.

Excessive health insurance costs for large and small businesses

Businesses that already insure their workers pay a high price for the failure of all businesses to fulfill this social responsibility. As Robert Crandall, Chairman of American Airlines, said, "Companies like ours pay for health care twice -- once for our own employees and then again, via taxes and inflated health insurance premiums, for the employees of those businesses who don't provide benefits for their own people."

Small businesses who enter the insurance market pay unnecessarily high costs because the current fragmented, inefficient insurance system for small businesses produces high sales and administrative costs, inadequate market power to organize efficient delivery of care, and excessive, costly switching between insurance companies. Small businesses with any employees in poor health often cannot purchase insurance at any price.

THE PROPOSAL

For working Americans, the legislation requires all employers to provide at least a basic, low-cost package of health insurance coverage for all full-time workers and their dependents in the same way that they are now required to pay all workers at least a minimum wage. The minimum plan must include protection against catastrophic costs. A system of regional insurers is created to assure the availability of community-rated, low-cost insurance to small businesses, and a subsidy program is established for small businesses facing excessive costs in complying with the mandate. Employers would be required to cover all employees and their dependents, regardless of health status. Employers are assured flexibility to design a plan of their choice, provided that minimum standards are met.

For Americans who are unable to participate in employment-based insurance, the legislation establishes a public Federal-state program that will provide subsidized insurance coverage. Because of the current budget crisis, the public program will be phased in gradually, beginning with the 6 million uninsured, poor Americans who cannot benefit from employment-based coverage. By the year 2000, all Americans will be covered by private or public plans.

IMPACT

--23 million members of working families (two-thirds of all the currently uninsured), including 7.5 million children, will be covered under the private program. Coverage under the first phase of the public program will result in insurance for an additional six million individuals, including 2.1 million children.

--56 million currently insured individuals will gain catastrophic coverage and more than 2 million families that annually experience catastrophic out-of-pocket costs of over $3,000 will be protected.

--7 million currently insured individuals who have health conditions that would make them uninsurable if they lost their current coverage will be able to change jobs without fear of loss of insurance protection.

--Significant reduction in hospital unreimbursed care costs: $5.2 billion.

--Significant savings for smaller firms now providing health insurance: $4.0 billion.

--Selected additional benefits include: coverage for 300,000 disabled children; cost-effective prenatal and well-baby care for 500,000 currently uninsured infants annually.

COST OF BILL

Actuarial Research Corporation(ARC), a respected independent actuarial firm, estimates that the average hourly cost of an indemnity plan meeting the bill's standards is 80 cents for a full-time worker. The employer's share of this cost will be 64 cents. ARC estimates that an employer choosing the managed care options, such as Preferred Provider Organizations(PPOs) and Health Maintenance Organizations(HMOs) can buy a plan at 15 percent less than the indemnity plan cost or about 54 cents per hour, equivalent to a 16 percent increase in the minimum wage. Businesses that currently insure their workers would experience reduced costs, because they would no longer have to pick up the costs of charity care and unreimbursed care for currently uninsured workers.

The total value of the health insurance purchased under the bill is an estimated $33 billion. Offsets for (1) administrative savings for small businesses; (2) potential managed care savings for small businesses; (3) replacement of high-cost, low-value individual policies; and (4) reduction in taxpayer and employer costs for charity care reduce the net cost to $18 billion. CBO has not yet completed its estimate of the cost of the first phase of the public program, but the phasing of the program can be adjusted, if necessary, to meet deficit-reduction targets.

IMPACT ON THE ECONOMY

The legislation will **assure fair competition** between businesses that insure their workers and those that do not. It will enhance international competitiveness since the firms that are at the cutting edge of international competitiveness already insure their workers and are paying additional costs to subsidize the health care of workers in firms that do not provide insurance. Because the legislation increases labor costs, it will reduce employment somewhat, **but the effect is minimal.** Professor Gerard Adams of the University of Pennsylvania analyzed the proposal using the well-known Wharton Econometric model and found no net effect on employment. The highest estimate of employment effects came from the Data Resources, Incorporated econometric model, and it found **a minimal increase in the unemployment rate of one-tenth of one percent.** The Consumer Price Index is estimated to increase an average of less than 2/10ths of one percent over the first three years, with no impact in subsequent years. The legislation will also reduce welfare dependency by removing one of the principal barriers to employment -- the loss of medical insurance.

ADVANTAGES FOR SMALL BUSINESS

Cost savings to firms currently offering coverage

Approximately sixty percent of workers employed in businesses of twenty-five employees or fewer work for firms that already provide health insurance coverage. Small businesses that provide health insurance to their employees face sales and administrative costs averaging twenty-five percent of total premium costs. For firms of ten employees or less, the cost is significantly higher. By contrast, large firms spend only five percent of premiums on sales and administration. By establishing regional contractors as described in the bill, ARC estimates administrative and sales savings in premiums of as much as ten percent compared to similar plans on the current market. In addition, the legislation will make managed care options available to small businesses that could reasonably be assumed to cut costs by an additional fifteen percent. **The result: a potential savings of 25 percent to small businesses.**

All small businesses will have guaranteed access to health insurance coverage without pre-existing condition exclusions through the regional insurer program.

Additional protection for small business

The bill recognizes that the cost of compliance with the legislation may be excessive for a minority of small businesses. Accordingly, the legislation establishes a subsidy program for small businesses that experience costs in excess of five percent of gross revenues in providing the required package of benefits. The subsidy will be 75 percent of costs in excess of this standard. Because gross revenues may not be the best measure of affordability in all industries, the Secretary of HHS is asked to conduct a study of the impact of such a standard and establish a different standard, if appropriate, for specific categories of business.

Impact on the American health care system

Basic Health Benefits **is not national health insurance.** Instead, the legislation maintains the American tradition of a pluralistic health care system and a private-public partnership to assure needed care. The system of private employment-based health insurance coverage for working families is maintained and expanded to all workers. Public coverage is restricted to individuals who are not full-time workers or dependents of workers and the direct provision of such coverage is reserved for States under Federal guidelines. All employment-based coverage is provided by private insurers, under new rules to improve the functioning of the small business health insurance market.

The legislation frees physicians, hospitals, and other health care providers to offer the best, most cost-effective care to all without regard to their ability to pay.

The Basic Health Benefits maintains the best of the current American health care system and assures that its benefits will be extended to all American families.

QUESTIONS AND ANSWERS-- THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

1. Q. IS BHB SIMPLY A BACKDOOR NATIONAL HEALTH INSURANCE PLAN?

A. No. BHB maintains the American tradition of a pluralistic private-public partnership to provide essential health care. it simply extends that system to the millions of citizens who have been unfairly left out. Two-thirds of the people gaining coverage through BHB will get their health insurance through private employment-based plans.

In fact, BHB is, in large measure, a private alternative to big government. It is intolerable to have thirty-seven million Americans without health insurance, and the government and the taxpayers will ultimately have to step in if the private sector does not do the job.

2. Q. HOW MUCH WILL BHB COST?

A. The respected non-partisan Congressional Budget Office estimates the value of the employment-based insurance purchased as a result of BHB at about $33 billion. The net cost is lower, about $18 billion, because there are savings from a number of sources. These include replacement of high-cost, low value individual coverage ($4.2 billion); coverage of some of the cost of hospital charity care which is now paid by taxpayers and businesses that insure their workers ($5.2 billion); and savings to small businesses from the regional insurer program and the opportunity to participate in cost-effective managed care systems ($4.8 billion). This estimate does not include, because there is insufficient data currently to calculate it, savings from allowing new small businesses to insure their workers under a lower cost plan.

To put these costs in perspective, they represent four tenths of one percent of total wages and fringe benefits and are less than three percent of current national health care costs.

CBO has not yet completed its estimate of the first phase of the public plan. The phasing of the public plan can be adjusted, if necessary, to be consistent with realistic deficit reduction targets.

3. Q. HOW MUCH WILL IT COST A BUSINESS TO PROVIDE INSURANCE TO ITS WORKERS IF IT HAS NOT PREVIOUSLY COVERED THEM?

A. The Actuarial Research Corporation estimates the average cost per worker of the minimum package provided as an indemnity plan at $1,619 in 1989, $883 for a single worker and $2,241 for a family plan. Since, in most cases, the employer is only required to pay 80 percent of the cost, the employer's share is generally $1,295 per worker. If an employer chooses to take advantage of a cost effective managed care option such as a PPO or an HMO, the cost would decline another fifteen percent, to $1,100 per year. This works out to about 55 cents per hour for a full-time worker.

4. Q. AREN'T THERE OTHER ESTIMATES PLACING THE COST OF BHB MUCH HIGHER?

A. Any new social program elicits wild estimates of its cost from those opposed to it. Our estimates of the cost of BHB come from the non-partisan Congressional Budget Office, which is relied on by Republicans and Democrats alike. CBO's estimates of the gross cost are partly based on premium estimates by the Actuarial Research Corporation, which is one of the most eminent independent actuarial firms in the country and has been a principal consultant to Administrations of both parties since the Nixon Administration in estimating the value of major new health programs.

5. Q. WHAT ARE THE PROBLEMS WITH SOME OF THE ALTERNATIVE ESTIMATES?

A. Opponents of the bill usually cite three alternative estimates of its cost. One study was commissioned by the Institute for Research on Economics and Taxation and carried out by Gary Robbins, a consultant. Robbins claimed BHB would cost $100 billion, four times as much as the CBO estimate. As CBO pointed out in its testimony before the Labor and Human Resources Committee on November 4, 1987, the Robbins study made four elementary errors. First, it overestimated the premium cost by $12 billion by assuming BHB would cost as much as an "average" employment-based plan. In fact, the benefits required under BHB are significantly less generous than the average employment-based plan provided today.

Second, the study assumed that there would be $45 billion in costs from duplicate coverage of employees in the same family working for different employers. As CBO and Professor Karen Davis also noted in separate analyses of the Robbins study, this estimate ignores the universal insurance company practice of coordination of benefits to avoid duplicate payments for overlapping coverage. These authorities concluded that there would be no additional cost from duplicate coverage, and even the author of the study admitted that any duplicate coverage costs would disappear after a few years.

Third, the study assumed upgrades in existing plans would cost $16.3 billion. CBO pointed out that an estimate like this ignores the actuarial equivalency rules of BHB, which allow employers not to meet many of the specific standards of the minimum plan, as long as their plan is of greater or equal total value. CBO found that the cost of upgrading additional plans would be only $2 billion, an amount included in the CBO estimate.

Finally, the study assumed additional administrative costs of $2 billion. The CBO found these costs to be negligible.

A second study sometimes cited by opponents of BHB is a study by Robert R. Nathan Associates. This study found the cost of BHB to be approximately $10 billion higher than the CBO estimate. CBO and GAO were asked to analyze the accuracy of the methodology used in the Nathan study. Both found the study to have made serious methodological errors that resulted in an excessively high estimate of cost. Specifically, the Nathan study:

--assumed that BHB premium costs would approximate the average costs of current employer-based plans, despite the fact that MHB is significantly less generous than current plans;

--failed to take into account the demographic characteristics of currently uncovered workers which may result in significantly lower average costs for them than covered workers; and

--used an indexing factor to project current costs to 1988 which was too high.

Finally, opponents sometimes cite studies by individual insurance companies or the HIAA in which the BHB benefit package is estimated by a company based on its own book of business. While these estimates are not too dissimilar from the Actuarial Research Corporation estimates, they are sometimes somewhat higher. Gordon Trapnell, President of Actuarial Research, listed the reasons why such estimates tend to be too high at the Labor Committee's November 4 hearing:

--the demographic characteristics of currently uninsured workers make them less costly to cover than currently insured workers; insurance company estimates based on their current book of business do not reflect these differences;

--average costs are reflected in the ARC estimates, rather than the costs of commercial insurance companies; these average costs include costs of Blue Cross plans that get substantial hospital discounts in some areas;

--reduction in the cost-shift from employers who currently offer health insurance to those who do not as the result of the enactment of BHB; these cost-shifts are built into insurance company estimates but would disappear under BHB;

--assumed retention rates for small businesses are higher in current insurance company business than would take place under the regional plan structure of BHB.

6. Q. **WON'T BHB REQUIRE EMPLOYERS ALREADY PROVIDING GOOD HEALTH INSURANCE PACKAGE TO UPGRADE THEIR EXISTING PLANS? I HAVE SEEN REPORTS FROM SURVEYS OF EMPLOYERS IN WHICH HIGH PERCENTAGES OF RESPONDING EMPLOYERS SAY THAT THEY WOULD HAVE TO MAKE SIGNIFICANT CHANGES IN THEIR HEALTH PLANS IF BHB IS ENACTED.**

A. Most such surveys ignore the provisions of the bill allowing actuarially equivalent plans. Under this provision of the bill, if an employer offers the basic plan benefits and the contribution that he would make to the health plan he offers is as good or better than he would make if he only offered the minimum plan, he is in compliance. For example, if an employer offers a benefit not required under the minimum plan--a drug benefit, for example--he could change some other aspect of the plan, such as raising the deductible. Because of the actuarial equivalency provision of the bill, CBO found only a small cost for upgrading existing plans.

7. Q. **WON'T MHB INCREASE UNEMPLOYMENT AND DAMAGE THE AMERICAN ECONOMY?**

A. Any increase in labor costs potentially adds to umemployment, but the impact of BHB will be minimal. The cost to an employer of insuring a full-time worker under a managed care option is 55 cents an hour. This is about equal to a 16 percent increase in the minimum wage, and we have had much higher increases in the minimum wage without negative employment impacts. Independent estimates of the economic impact of BHB have been conducted by Professor Karen Davis; the Data Resources, Incorporated, economic model; The Wharton economic model; and CBO. The Davis and Wharton estimates, which take into account offsetting increases in employment in the health care sector, found no net job loss as the result of the bill. The DRI and CBO estimates, which did not take into account offsetting employment gains in health care, found a minimal increase in unemployment of one-tenth of one percent or less over a three year period.

The same public philosophy that says we cannot afford BHB also said that we could not afford Social Security, or Medicare, or unemployment compensation, or the minimum wage, but our society is richer, not poorer, because these programs were enacted.

8. Q. THE UNITED STATES IS STRUGGLING WITH A MOUNTING TRADE DEFICIT AND FACING INCREASING DIFFICULTY IN COMPETING WITH FOREIGN COUNTRIES. WON'T BHB EXACERBATE THIS PROBLEM?

A. No. In fact, BHB will improve the United States' ability to compete in world markets. That is one reason that the Chrysler Corporation, one of the U.S. companies that is facing the stiffest foreign competition, has endorsed BHB. The companies that are at the cutting edge of international competition almost universally insure their workers. In fact, ninety-seven percent of all workers in manufacturing firms are employed by businesses that provide health insurance already. But firms that insure their workers pay too much for that insurance because other companies do not fulfill their social responsibilities. When an uninsured worker is seriously ill and requires hospitalization, he generally gets taken care of. That care is not free; it is paid for by higher charges to other patients and higher insurance premiums for companies that insure their workers.

9. Q. WON'T BHB IMPOSE COSTS THAT SMALL BUSINESSES CANNOT AFFORD?

A. It is important to set the record straight. First, the problem of businesses that do not insure their workers is not unique to small business. In fact, almost a quarter of uninsured employees work for businesses with 1,000 or more employees. Second, the majority of small business employees already work for firms that offer plans -- 60 percent in businesses with 25 or fewer employees. This percentage rises to almost three quarters for firms of under 100 and 80 percent for firms of under 500. Every one of the small businesses that currently insure their workers pays too much for that insurance and faces unfair competition because other businesses do not fulfill this obligation.

Small businesses face special problems in gaining affordable insurance. Sales and administrative costs for small businesses of less than 25 workers average 25 percent, compared to 5 per cent for larger businesses. The mark-up for businesses with fewer than 10 workers is even higher. Because the practice of health screening is virtually universal for very small businesses, some small businesses can not get health insurance at any price or must exclude some workers or the owner of the business from coverage. Current insurance company practices in the small business market guarantee excessive turnover and force companies with even a few unhealthy workers to pay excessive premiums, if coverage is available at all.

In addition, the owner-operator of an unincorporated small business faces discriminatory tax treatment when he purchases insurance. The hired manager of a large corporation does not pay any tax on the share of his premium paid for by his business.

The self-employed businessman must pay taxes on all but 25 percent of his premium.

BHB helps all small businessmen who currently insure their workers and lowers prices for those newly required to buy insurance through a system of regional insurers. These regional insurers will offer economies of scale and reduced sales and administrative costs sufficient to cut the price of insurance by 10 percentage points. Under the regional insurer program, economical managed care options such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) will be readily available to small businesses. These managed care organizations will cut the cost of insurance by an additional 15 percent or more. Small businesses will also have guaranteed availability of coverage at community rates, regardless of the health status of employees and owners.

BHB allows new small businesses of 10 employees or fewer to offer their employees only a low-cost catastrophic plan rather than the full minimum plan in the first two years, when the business is most fragile. Full coverage of the smallest businesses (five employees or fewer) is phased in over a five year period to allow more time for adjustment. In addition, companion legislation to BHB reforms the unfair tax treatment of self-employed businessmen.

A significant new provision of BHB will provide additional protection for small businesses: small businesses who must pay an excessive amount to comply with the requirements of the bill will receive a Federal subsidy to help with those costs. Specifically, small businesses that spend more than five percent of gross revenues in providing the require coverage will receive a subsidy covering 75 percent of the overage. The Secretary of HHS will be authorized to provide an alternate, equivalent standard for industries for which the gross revenue test is not appropriate.

10. Q. **MANY FEDERAL PROGRAMS REGULATING BUSINESS PRACTICES EXEMPT SMALL BUSINESSES. WHY DOESN'T BHB HAVE A SMALL BUSINESS EXCLUSION?**

A. A small business exclusion would reduce the impact of the bill dramatically and leave far too many workers without health insurance coverage. Forty-eight percent of uncovered workers are employed by businesses with fewer than 25 employees. Thirty-six per cent work for businesses with fewer than ten employees. Twenty-one percent work for businesses with fewer than five employees.

Moreover, excluding small businesses would deny them the benefit of the low cost, community-rated coverage offered by the regional insurers established by the bill. The incentives for risk-skimming, adverse selection, and the continued problem of high rates of enrollment and disenrollment that occur in a voluntary system make participation in the regional insurer program impractical if participation is not mandatory. Thus, a small business exclusion would mean that small businesses would continue to face high costs and lack of guaranteed availability when they purchase health insurance coverage. This not only prevents employees from gaining essential health insurance coverage, it continues the competitive disadvantages small businesses face relative to larger firms.

11. Q. **WON'T BHB CREATE A NEW ROUND OF HEALTH CARE COST INFLATION BY INCREASING DEMAND FOR HEALTH CARE SERVICES?**

A. No. This point was examined by Professor Karen Davis, by the CBO, and by Professor F. Gerard Adams and they all concluded that the net increase in health care spending generated by BHB was so small relative to the total size of the health care industry and the existing overcapacity in the industry was so great, that no significant increase in inflation rates would result. Indeed, Professor Adams suggested that inflation rates might actually come down because increased volume of services might reduce pressure to raise charges to cover overhead or reach target incomes.

12. Q. CAN'T THE OBJECTIVES OF BHB BE REACHED BY INCENTIVES RATHER THAN A MANDATE?

A. This is an argument often made by those who want to defeat BHB, but even a superficial analysis of the so-called incentives reveals their inadequacy. They generally suggest establishing the tax reform already introduced as a companion measure to BHB and allowing a subsidized buy-in to Medicaid for low-income workers, and argue that these measures plus the growth in multi-employer trusts (METS) will somehow solve the problems faced by small businesses.

The fact is that these proposals are just a smokescreen. Fairer tax treatment for the self-employed is desirable, but a minor incentive at best. Subsidized buy-ins for Medicaid or other public programs are desirable, and they are a feature of BHB. However, covering all the uninsured who are not workers or dependents of workers through public funds will be extremely difficult given the current budget situation. To try to extend such a program to the working uninsured as well would cost approximately three times as much and would be competely impractical. Moreover, such a program would induce the vast majority of employers that currently insure their workers to drop coverage for low income employees and let the taxpayers pick up the cost.

METs can produce some reductions in administrative costs, but not nearly as much as the BHB proposal. METs almost universally apply medical screening, rarely are big enough to have the market power to organize effective systems of managed care, and face continued sales and enrollment/disenrollment costs because they do not function in an environment of required, universal participation. The inadequacy of the MET approach is shown by the fact that, at the same time METs have grown, the number of the uninsured has been increasing at almost a million a year.

13. Q. IS BHB AN UNPRECEDENTED INTERFERENCE WITH THE RIGHT OF THE MARKET TO DETERMINE APPROPRIATE EMPLOYEE COMPENSATION?

A. We require employers to pay a minimum wage, to participate in Social Security and Medicare, to join the unemployment compensation system and to pay to support it, and to pay for workman's compensation insurance. Most Americans would agree that our society is better off as a result of these requirements. In 1988, it is time to require the universal provision of health insurance coverage to all workers.

14. Q. ISN'T IT UNREASONABLE TO REQUIRE FIRMS TO COVER EMPLOYEES WORKING AS FEW AS 17.5 HOURS A WEEK? DOESN'T THIS MAKE IT UNECONOMIC TO HIRE A PART-TIME WORKER EVEN IF THERE IS A GENUINE NEED?

A. The seventeen and one-half hour standard was chosen because it was consistent with the non-discrimination rules included in the Tax Reform Bill and because the sponsors wanted to avoid creating an incentive for employers to reduce workers hours by an hour or two simply to avoid the requirement to provide health insurance coverage. As introduced this year, the legislation responds to this concern by allowing the employer to make a proportional contribution based on hours worked for employees working less than 25 hours per week.

15. **Q. HOW WILL THE PUBLIC PORTION OF BHB BE FINANCED?**

A. BHB will be jointly financed by the Federal and state governments. State expenditures will be matched by the Federal government at the same matching rates used in the Medicaid program.

16. **Q. HOW CAN THE COST OF A LARGE PUBLIC PROGRAM FOR THE UNINSURED BE JUSTIFIED AT A TIME OF GREAT CONCERN ABOUT THE SIZE OF THE FEDERAL DEFICIT?**

A. Any new program increasing Federal spending must be consistent with an overall program to reduce the deficit. The sponsors of this legislation believe that health care for all Americans should be one of Congress's highest priorities--sufficiently high that it should be funded within overall budget constraints. If room cannot be found in the budget to fund the program as introduced, the phasing in of the program can be modified. Regardless of the schedule under which the program is ultimately phased in, however, the time is long overdue for the Congress to make a firm commitment to assuring that the basic human right to health care will ultimately be a reality for all Americans.

17. **Q. HOW WILL IT BE ADMINISTERED?**

A. As in the existing Medicaid program, BHB will be administered by the states subject to Federal law and guidelines.

18. **Q. HOW WILL THE PUBLIC PROGRAM UNDER BHB RELATE TO THE EXISTING MEDICAID PROGRAM?**

A. States will continue to have the option to cover individuals eligible for Medicaid under the Medicaid program rather than BHB.

SPECIFICATIONS FOR BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT AS INTRODUCED IN THE 101ST CONGRESS

PRIVATE PROGRAM

I. INCORPORATES PROVISIONS OF S.1265, the Minimum Health Benefits for All Workers Act, as reported from the Senate Committee on Labor and Human Resources:

--EMPLOYERS PROVIDE INSURANCE MEETING MINIMUM STANDARDS TO ALL WORKERS AND DEPENDENTS

--MINIMUM PACKAGE INCLUDES:

- o physician services
- o hospital services
- o diagnostic tests
- o prenatal/well-baby care
- o limited mental health coverage
- o catastrophic coverage ($3,000 out-of-pocket limit)

--MAXIMUM DEDUCTIBLES/CO-PAYMENTS:

- o $250 deductible/individual
- o $500 deductible/family

- 20% co-payment
- no deductibles or co-payments on prenatal/well-baby care

--MAXIMUM EMPLOYEE SHARE OF PREMIUM: 20%

--NO EXCLUSIONS FROM COVERAGE BASED ON HEALTH STATUS

--ACTUARIAL EQUIVALENCY TEST ALLOWS FLEXIBILITY IN BENEFIT DESIGN

--REGIONAL CONTRACTORS PROVIDE COMMUNITY-RATED INSURANCE COVERAGE FOR CURRENTLY UNINSURED AND SMALL BUSINESSES

--ANY INSURER MAY BE CERTIFIED AS A REGIONAL CONTRACTOR IF IT IS WILLING TO MEET THE REQUIREMENTS OF THE ACT

--REGIONAL CONTRACTORS OFFER:
- indemnity and managed care plans
- economies of scale
- minimum and comprehensive coverage

--COMPLEMENTARY LEGISLATION ESTABLISHES TAX DEDUCTIBILITY OF SELF-EMPLOYED HEALTH INSURANCE PREMIUM

II. ADDITIONAL PROVISIONS

--SUBSIDY FOR SMALL BUSINESS FOR WHOM COMPLIANCE IS AN EXCESSIVE BURDEN
- Subsidy provided if cost of minimum plan exceeds 5% of gross revenues
- Subsidy equals 75% of excess cost
- Secretary will establish alternate standard for industries for which gross revenue standard is inappropriate

--PROPORTIONAL CONTRIBUTION FOR PART-TIME WORKERS
- Employers will be allowed to make a proportional contribution for part-time workers working between 17.5 and 25 hours per week
- Workers working less than 25 hours per week may decline coverage

III. COMPLEMENTARY LEGISLATION

- Establishes full tax deductability for self-employed health insurance premium

- Simplifies and reduces "Section 89" non-discrimination rules

PUBLIC PROGRAM

--ALL AMERICANS ASSURED HEALTH INSURANCE COVERAGE BY THE YEAR 2000

--PUBLIC PROGRAM AVAILABLE TO ANY AMERICAN NOT COVERED BY EMPLOYMENT-BASED COVERAGE

--IN RESPONSE TO BUDGET REALITIES, PUBLIC PROGRAM IS PHASED IN
- Phase I (Implemented simultaneously with private program) - Covers all poor Americans with no health insurance (6 million people)

- Phase II - (1996) Covers those between 100 and 185% of the poverty level (4 million people)
- Phase III - (1999) Covers remainder of uninsured population (5 million people)

--BENEFITS/PREMIUMS
- Same package as private plan
- No co-payments, deductibles or premiums for those less than 100% of poverty
- Co-payments, deductibles and premiums related to income for those at 100-185% of poverty
- Those who are above 185% of poverty pay actuarial cost of coverage for public program enrollees

--PAYMENT TO PROVIDERS
- As in private program, states must offer payment rates at levels adequate to assure access

--FINANCING AND ADMINISTRATION
- Program administered by states under Federal guidelines
- Federal match of eligible state expenditures at Medicaid rates
- States must offer managed care and fee-for-service options

ORGANIZATIONS ENDORSING THE CONCEPT OF THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

AIDS Action Council
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Nurse Practitioners
American Academy of Physical Medicine and Rehabilitation
American Airlines
American Agricultural Movement (AIM)
American Association for Counseling and Development
American Association for Marriage and Family Therapy
American Association of University Affiliated Programs for Persons with Developmental Disabilities
American College Health Association - Nurses' Section
American College of Emergency Physicians
American Congress of Rehabilitation Medicine
American Diabetes Association
American Ethical Union
AFSME
AFL-CIO
Americans for Indian Opportunity
American Hospital Association
American Jewish Congress
American Medical Students Association
American Nurses' Association
American Osteopathic Hospital Association
American Protestant Health Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Internal Medicine
Association of American Medical Colleges
Association for Children and Adults with Learning Disabilities
Association for Hospital Medical Association

Association for Retarded Citizens of the United States
Association of Schools of Public Health
Baxter-Travenol Laboratories
Black Women's Agenda
Building and Construction Trades Department, AFL-CIO
Catholic Charities
Catholic Health Association of the United States
Center for Women Policy Studies
Child Welfare League
Children's Defense Fund
Church of the Brethren
Church Women United
Citizen Action
City of New York
Columban Fathers Justice and Peace Office
Communications Workers of America
Comprehensive Family Care Center
Consumer Federation of America
Displaced Homemakers Network
Enlisted Association of the National Guard of the United States
Epilepsy Foundation of America
Family Service America
Federally Employed Women
Federation of American Health Systems
Industrial Union Department, AFL-CIO
International Ladies Garment Workers Union
International Union of Bricklayers and Allied Craftsmen
International Union of Operating Engineers
Jesuit Social Ministeries
League of Rural Voters
Lutheran Office for Governmental Affairs, Evangelical Lutheran Church in America
Mental Health Law Project
National Abortion Rights Action League
National Association for Home Care
National Association of Children's Hospitals and Related Institutions
National Association of Commissions for Women
National Association of Community Health Centers
National Association of Counties
National Association of Nurse Practitioner Faculties
National Association of Nurse Practitioners in Reproductive Health
National Association of Private Psychiatric Hospitals
National Association of Protection and Advocacy Systems
National Associations of Public Hospitals
National Assocation of Rehabilitation Facilities
National Association of Social Workers
National Association of Temporary Services
National Caucus and Center on Black Aged, Inc.
National Conference of Gerontological Nurse Practitioners
National Council of Churches
National Council of Community Hospitals
National Council of Community Mental Health Centers
National Council of Jewish Women
National Council of Negro Women
National Education Association
National Farmers Organization
National Farmers Union
National Federation of Societies for Clinical Social Work, Inc.
National Head Injury Foundation
National Health Care Campaign (161 affiliated Health, Civic, and Labor organizations)
National Hospice Organization
National Institute of Women of Color
National Insurance Consumers Organization
National Mental Health Association

National Multiple Sclerosis Society
National Organization for Rare Disorders
National Parkinson Foundation, Inc.
National Rehabilitation Association
National Save the Family Farm Coalition
National Union of Hospital and Health Care Workers, 1199
National Women's Law Center
National Women's Party
National Women's Political Caucus
NETWORK: A Catholic Social Justice Lobby
New York City Health and Hospitals Corporation
Older Women's League
Retail, Wholesale and Department Store Union
Service Employees International Union
Teamsters Union
The United Methodist Church / General Board of Church and Society Department of Human Welfare
Unitarian Universalist Association of Congregations, Washington Office
United Association of Journeymen and Apprentices of the Plumbing and Pipe-fitting Industry of the U.S. and Canada
United Auto Workers
United Cerebral Palsy Associations, Inc.
United Federation of Teachers
United Food and Commercial Workers Union
United Mineworkers of America
United Steelworkers of America
Washington Office of the Episcopal Church
Washington Office, Presbyterian Church, U.S.A.
Western Association of Children's Hospitals
Women's Equity Action League
Women's International League for Peace and Freedom
World Institute on Disability

THE ECONOMIC IMPACT OF EMPLOYER MINIMUM HEALTH INSURANCE COVERAGE

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Testimony before the
U. S. Senate
Committee on Labor and Human Resources

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Thank you, Mr. Chairman, for this opportunity to testify on the economic impact of employer minimum health insurance coverage. Gaps in employer-provided health insurance pose significant barriers to needed medical care and undermine the health and economic security of many working families. Requiring employers to provide minimum health insurance coverage to workers would markedly reduce the ranks of the uninsured, improve access to health care, and relieve the financial hardship of health care bills for 24 million Americans.

Today, I would like to review the health and economic consequences of failing to close the gaps in health insurance coverage, as well as discuss how the cost of health care would be distributed under a mandated employer health insurance plan. The economic consequences, including any potential effect on employment, of a minimum employer plan deserve careful consideration and I am pleased to share with the Committee my own analysis of this aspect of the plan.

The Uninsured and Health Care

As previous hearings have documented, 37 million Americans, or about 17.6 percent of the nonelderly population, do not have any health insurance coverage. Particularly disturbing is the fact that the ranks of the uninsured are growing. In 1980, 30 million Americans, or 15 percent of the nonelderly population, did not have health insurance coverage. Today there are 7 million more Americans without health insurance coverage than was the case six years ago.

The common impression is that the uninsured are outside the work force -- mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Seventy percent of all the uninsured are in families where at least one member works at least 10 or more hours per week. The remaining 30 percent are unemployed or out of the labor force.

Nearly all of the uninsured have modest incomes. About one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured.

Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays. A spell of illness, hospital episode, or chronic health problem incurred by the uninsured can be financially devastating.

Recent studies document the seriousness of absence of health insurance coverage for access to health care. A new report on access to health care in 1986 recently released by the Robert Wood Johnson Foundation contains evidence on the deterioration in access to health care in the 1980s. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but did were turned away.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured. One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not only a serious financial problem it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Alternative Approaches to Closing the Gaps in Health Insurance Coverage

It is urgent that action be taken to provide at least some minimum essential health insurance coverage for all Americans. In evaluating the economic impact of any one approach to dealing with this problem, it is important to consider the alternatives. The major approaches which could be followed to close the gaps in health insurance coverage include:

- Expanding public programs such as Medicaid or Medicare to cover the uninsured or establishing a new public program,
- Subsidizing the purchase of individual private health insurance through federal or state government funds,
- Taxing hospitals or private health insurance plans to create a pool for paying for care for the uninsured, or
- Requiring employers to provide health insurance coverage for employees and dependents.

The first of these alternatives would require substantial new taxes from corporations or individuals. Given current governmental budgetary problems, public funds might be better targeted on those low-income uninsured falling outside the workforce. In addition since some of the working poor and near-poor have private health insurance coverage through employers, public coverage would displace current private coverage and add considerably to public outlays.

The second approach would also require additional taxes to pay for subsidies of an inherently inefficient type of health insurance coverage. Individual health insurance plans run administrative costs 30 to 50 percent of benefits, compared to 3 to 5 percent for Medicare and Medicaid. Public monies would go further by directly covering the uninsured under Medicaid or Medicare than by indirectly subsidizing coverage under individual private health insurance plans.

The third approach of taxing hospitals or private health insurance plans would shift the financial burden of covering the uninsured onto the insured. Those employers providing coverage for their workers would be doubly burdened--picking up the costs of their own workers plus the cost of workers in firms not providing such coverage. In a given industry, firms providing health insurance coverage for workers would be at a serious competitive disadvantage to those firms not providing such coverage.

In the light of these alternatives, requiring minimum employee health insurance coverage has much to commend it. It would minimize new taxes required to fill the gaps in health insurance coverage. It would build on the current system of employer-provided private group health insurance. It would spread the cost of expanded coverage more equitably among firms, rather than concentrating the burden on those firms voluntarily electing to provide coverage to their workers.

Economic Cost of a Minimum Employer Health Insurance Plan

There are several cost concepts which need to be considered in evaluating the economic impact of a minimum employer health insurance plan. The incremental cost of coverage to society is the additional health services or expenditures which would result from improved coverage. Simply put, people who now fail to get health care for financial reasons could be expected to receive it. More pregnant women would receive adequate prenatal care; more hypertensives would receive regular attention from a physician.

Other costs are transferred from one party to another. The uninsured would have lower out-of-pocket expenses for health care; these costs would be shifted to their employers.

Those individuals purchasing individual private health insurance would have reduced premiums. Those premiums would be paid by their employers.

The ultimate burden of such expenses, however, might be shifted onto others. Employers might elect to lower wages (or raise them less than they otherwise would) if forced to pay for health insurance coverage. In this case, the cost of health care for the sick uninsured would be spread over all uninsured workers in the form of reduced wages rather than concentrated on those uninsured with serious illnesses. Since group insurance is less costly than individual insurance, workers who now purchase individual insurance would have a net reduction in premium cost and out-of-pocket costs.

If the employer were unable to shift the cost onto workers, because of minimum wage provisions, these costs might be shifted onto stockholders in the form of lower profits or consumers in the form of higher prices.

S. 1265 could be expected to have a modest incremental economic cost and result in transfers of costs from individuals and governments to employers. These costs in turn would likely be shifted largely onto workers. Estimates from the Actuarial Research Corporation of S. 1265 appear to be the most reasonable estimates of the premium cost of the mandated plan. These estimates indicate that an individual plan would cost $642 annually; a family plan would cost $1,631; and the per worker cost would average $1,186 in 1988. I have compared these estimates with estimates of employer-mandated coverage I was responsible for in 1980 and find them within the right range given increases in health care expenditures since that time.

Actuarial Research Corporation notes that costs would be lower for workers choosing to obtain care through HMOs as the plan encourages. This, too, is corroborated by other research studies.

Data from the 1985 Consumer Population Survey suggest that 13 million uninsured workers would be newly covered by S. 1265, or a total of 24 million people including family members. In addition 6 million workers who now purchase health insurance coverage individually would be covered under employer-provided group coverage. Applying the per worker rates to these counts of affected workers suggests a total cost of about $23 to $25 billion in 1988.

These costs, however, are largely transferred costs rather than new economic costs. Roughly, it could be expected that $5 billion would displace current governmental outlays (e.g. under Medicaid, VA, and state and local government hospital subsidies). Another $15 billion would displace out-of-pocket payments for health care by uninsured individuals and individual insurance premium payments for those with individual health insurance. The remaining $5 billion would represent new health expenditures for health care which would not currently be received by the uninsured.

These outlays are modest given the current size of the health care sector. In 1986, national health expenditures were $458 billion, of which over $185 billion came from government, $115 billion came from consumers directly out-of-pocket, $145 billion came from private health insurance payments, and the remainder from miscellaneous private sources.

Viewed from this perspective, the proposed bill would add about one percent to total outlays for health care, increase the private share of total health spending from 59 to 60 percent, and reduce the out-of-pocket share of health spending from 28 percent to about 26 percent. These are not revolutionary shifts in health outlays and could be expected to have only modest effects.

From the perspective of the uninsured, however, the plan would provide health insurance coverage for an additional 24 million Americans, remove the financial obstacles to obtaining health care for children, pregnant women, and those with chronic health problems, avoid postponing care for serious health symptoms such as bleeding or loss of consciousness, and lift the crushing financial burden a serious health problem can inflict.

Inflationary pressure from the new expanded pressures can be expected to be minimal. The health sector is currently experiencing serious excess capacity -- both in terms of low hospital occupancy rates and a significant increase in the supply of physicians. New health care services by those who are currently uninsured could be accommodated easily within the current system without generating inflationary pressures.

Minimum Health Coverage and Impact on Employment

In large part additional employer costs could be expected over the longer term to result in lower wages than would otherwise have been paid. The exception to this is those workers at or near the minimum wage where the employer could not legally lower wages. Data Resources Institute estimates that this would result in reduced employment on the order of 100,000 to 120,000 jobs, or add about 0.1 percentage points to the unemployment rate. This is a relatively small change in the context of the creation of 16 million new jobs in the last three years, and would be much smaller than the employment impact of efforts to cut federal budgetary outlays under a deficit reduction effort.

This estimate would appear to be within a plausible range. Currently, 4 million workers with wages less than $4.00 per hour are uninsured. Over 90 percent of these workers work at least 25 hours per work; at least 75 percent work 35 or more hours per week. The employer share of the premium would average about 50 cents per hour for most uninsured workers. Studies suggest that a 15 percent increase in the minimum wage might result in a 1.5 percent reduction in jobs. Applying these to the 4 million workers suggests about a 60,000 loss of jobs. Thus, the 100,000 to 120,000 figure would appear to be an outside estimate.

One important point, however, is that the additional health services received by the uninsured under this plan would in itself have an employment stimulating effect. The $5 billion in new health expenditures could be expected to add at least 100,000 jobs in the health sector. The net employment impact of the bill, therefore, may be positive rather than negative. This should not be surprising since most new "spending" programs are expansionary rather than contractionary, even when financed by additional revenues.

IRET Estimate of Economic Impact

A study by Robbins and Robbins for IRET has estimated that the employer minimum health plan would cost $100 billion and result in a loss of one million jobs. This study contains at least four serious flaws:

- It overestimates the per worker cost of the S. 1265 benefit package.
- It erroneously assumes that most employers would be forced to upgrade existing health insurance coverage.
- It fails to take account of coordination of benefit provisions in private health insurance plans that would avoid duplicate payments for services.
- It does not consider the employment expansionary impact of providing new health services.

The study assumes that the per worker cost would be over $2,000, resulting in a cost of $37 billion for 17 million newly covered workers. This is far in excess of the Actuarial Research Corporation estimate and can not be reasonably justified.

The IRET estimated cost exceeds the cost of current employer-provided health insurance coverage. In 1988 employers will be expected to spend over $120 billion on health care coverage for 81 million workers. The average per worker cost of health coverage will be over $1,500.

Current employer plans on average are more generous, not less generous, than the minimum plan. The minimum plan requires a family deductible of $500 and a maximum out-of-pocket cost of $3,000. A survey of employer plans by Louis Harris and Associates for Equitable in 1985 found that over half of employer plans had deductibles below $100. A survey of employer plans in 1984 by Hewitt Associates found that 37 percent had no deductible for hospital care and half had a total deductible of less than $100. The minimum plan with its high deductible can be expected to cost considerably less than the typical plan now covering workers.

The IRET cost of new coverage of $37 billion, therefore, is a gross overestimate. In addition, since current employer plans are more generous, not less generous than the minimum plan, there would be no $16 billion cost for upgrading coverage. Employers could add any uncovered benefits such as well-baby care for no additional cost by raising current deductibles.

Finally, the IRET study erroneously assumes that there would be $45 billion in duplicate insurance coverage. Private health insurance plans have quite sophisticated systems for coordinating benefits when a two-earner family is covered by multiple plans. Rules followed by companies specify which plan is primary payer. Beneficiaries do not receive double payment for health care services received. The $45 billion duplicate coverage cost, therefore, is inapplicable.

Numerous other criticisms could be raised about the IRET analysis. Administrative costs of group insurance, for example, are considerably less than individually purchased insurance. The estimated $2 billion incremental administrative cost does not consider these offsets.

Summary

The minimum employer plan would accomplish much for a modest outlay and minimal adverse economic effects. The benefits contained in S. 1265 do not constitute an excessively generous or financially burdensome plan. It is estimated that the plan would cost $23 to $25 billion, or $1,200 per newly covered worker, or on an hourly basis about $0.50 to $0.60 per hour.

The plan is likely to be expansionary rather than contractionary. The direct job loss from higher labor costs is at most 100,000 to 120,000. The additional jobs created in the health sector by expanded demand for services would be at least 100,000. Other factors suggest that any adverse effect on employment would be minimal. The labor market for entry-level workers is tightening with the drop in fertility in the mid-1960s leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. The minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last six years. Finally, the types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Coverage of employers and dependents under this plan would add 24 million more people to health insurance coverage, and drop the number of uninsured from 37 million to about 13 million. This would provide much needed improvement in access to health care for a largely low-income population. It would help reduce the intolerable delay in obtaining needed health care for pregnant women, children, those with chronic health problems such as hypertension and diabetes, and those with life-threatening symptoms such as bleeding, chest pain, and loss of consciousness which many uninsured now experience.

A balanced assessment suggests that mandating employer coverage for workers and their families would be the least disruptive and fiscally burdensome approach to helping close the gap in health insurance coverage of Americans. It deserves serious consideration. Thank you.

CAMBRIDGE REPORTS TRENDS & FORECASTS

Demographic Analysis

Survey date: Q3/88
Sample size: 1445
Variable#: 041

QUESTION:

Please tell me whether you favor or oppose requiring businesses to provide employees who work 17.5 hours a week or more with a minimum amount of health care insurance, as an alternative to government programs.

1. Favor
2. (Don't know)
3. Oppose

		1.	2.	3.
National sample		74	7	19
Total household income	$0-7,999	86	5	6
	8-14,999	76	8	16
	15-24,999	73	6	21
	25-34,999	72	8	20
	35-49,999	73	6	21
	$50,000 and over	65	5	30
Age	18-25	72	13	15
	26-35	75	6	19
	36-45	74	6	21
	46-55	74	4	21
	56-65	76	3	21
	Over 65	74	9	17
Sex	Female	75	7	18
	Male	73	7	19
Race	White	72	7	21
	Black	85	9	6
Education	Some grade school	80	10	10
	Some high school	78	10	13
	High school grad	77	7	16
	Some post-H S	71	6	23
	College grad	65	9	27
	Grad school	73	2	25
Political ideology	Liberal	77	7	16
	Moderate	73	9	18
	Conservative	73	5	21
Urban/rural	Urban	73	11	16
	Suburban	76	6	18
	Rural	72	5	23
Area	Northeast	71	11	18
	Industrial	73	8	19
	Midlands	74	6	20
	South	81	5	14
	Central	72	5	23
	Pacific	72	9	19

To obtain other demographic analyses or subscription information, please call or write Karen Dwyer at our Cambridge office

Cambridge Reports, Inc.
675 Massachusetts Ave.
Cambridge, MA 02139
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HEALTH CARE PRIORITIES IN 1988

THE PUBLIC'S VIEW

Conducted for:

The Federation of American Health Systems

Prepared by:

The Gallup Organization, Inc.

[illegible] in January [illegible]

Employers Should Provide Health Care Insurance

	Yes %	No %	Don't know %	Total %	Number of Interviews
Total	73	22	5	100	(1014)
Age					
Under 30 years	82	14	3	100	(231)
30-44 years	72	26	2	100	(382)
45-59 years	65	29	6	100	(226)
60 years & over	73	18	10	100	(168)
Education					
Less than H.S. Grad.	84	12	5	100	(130)
H.S. Grad.	76	19	5	100	(367)
College	66	30	4	100	(514)
Annual Household Income					
Less than $20,000	79	17	4	100	(235)
$20,000 - $39,999	75	22	2	100	(366)
$40,000 or more	66	31	4	100	(302)

Nonelderly Population with Selected Sources of Health Insurance by Region, and State, 1986

(in thousands)

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
Total	208,023	152,898	136,123	23,828	24,883	16,985	37,027
New England	10,916	8,805	7,939	1,189	990	587	1,333
Maine	953	732	635	118	105	a	145
New Hampshire	883	745	689	99	a	a	101
Vermont	461	359	326	a	a	a	69
Massachusetts	5,085	4,095	3,688	528	513	404	605
Rhode Island	824	700	633	94	83	a	69
Connecticut	2,710	2,173	1,969	350	289	183	345
Middle Atlantic	31,893	24,405	22,071	3,338	3,675	2,982	4,567
New York	15,286	11,052	10,030	1,551	2,008	1,707	2,556
New Jersey	6,682	5,393	4,858	729	585	453	825
Pennsylvania	9,925	7,960	7,183	1,058	1,082	821	1,185
East North Central	36,378	27,956	25,259	3,880	4,488	3,447	5,133
Ohio	9,356	7,153	6,499	939	1,036	838	1,409
Indiana	4,654	3,630	3,258	541	342	182	833
Illinois	10,093	7,606	6,838	1,065	1,333	1,040	1,481
Michigan	8,133	6,199	5,638	860	1,306	1,037	965
Wisconsin	4,143	3,367	3,026	476	470	350	444
West North Central	15,209	11,944	10,000	2,463	1,544	1,166	2,122
Minnesota	3,670	2,931	2,418	636	475	397	389
Iowa	2,532	2,035	1,640	495	280	236	295
Missouri	4,391	3,328	2,941	471	471	340	714
North Dakota	548	443	325	143	a	a	87
South Dakota	595	463	349	138	a	a	103
Nebraska	1,383	1,069	897	239	130	86	234
Kansas	2,090	1,673	1,430	341	188	108	299
South Atlantic	34,639	25,581	22,717	4,050	3,892	2,116	6,393
Delaware	553	421	387	a	a	a	99
Maryland	3,972	3,133	2,869	396	350	211	617
District of Columbia	526	365	329	a	a	a	112
Virginia	4,799	3,808	3,466	473	626	260	622
West Virginia	1,621	1,106	959	189	297	218	295
North Carolina	5,364	3,997	3,574	644	533	295	985
South Carolina	2,840	2,092	1,888	330	406	232	468
Georgia	5,311	3,891	3,519	606	677	431	954
Florida	9,653	6,767	5,725	1,412	1,004	469	2,242

(continued on next page)

Nonelderly Population with Selected Sources of Health Insurance by Region, and State, 1986
(Continued)

Region by State	Total	Total Private	Total Employer	Other Private	Total Public	Medicaid	No Health Insurance Coverage
			(in thousands)				
East South Central	12,973	8,658	7,665	1,526	1,800	1,182	2,950
Kentucky	3,139	2,151	1,895	340	448	304	659
Tennessee	4,010	2,725	2,429	470	620	380	826
Alabama	3,575	2,378	2,144	365	430	294	859
Mississippi	2,249	1,404	1,197	351	303	205	606
West South Central	23,290	15,494	13,827	2,582	2,656	1,542	5,861
Arkansas	2,007	1,312	1,153	246	295	165	487
Louisiana	3,920	2,548	2,234	520	599	416	904
Oklahoma	2,793	1,943	1,690	351	332	153	636
Texas	14,569	9,691	8,751	1,465	1,430	808	3,833
Mountain	11,354	8,351	7,191	1,482	1,085	305	2,242
Montana	715	525	408	153	88	a	134
Idaho	863	626	524	132	a	a	196
Wyoming	441	329	283	a	a	a	78
Colorado	2,769	2,052	1,778	374	384	200	450
New Mexico	1,249	827	670	190	142	a	325
Arizona	2,895	2,129	1,832	394	221	a	651
Utah	1,546	1,181	1,080	139	155	105	253
Nevada	878	682	617	99	95	a	154
Pacific	31,369	21,705	19,454	3,038	4,263	3,022	6,427
Washington	3,808	2,739	2,394	447	656	420	603
Oregon	2,401	1,753	1,573	218	233	167	478
California	23,874	16,217	14,629	2,219	3,270	2,434	5,142
Alaska	453	324	271	a	a	a	97
Hawaii	833	672	587	154	104	a	107

Source: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

a - Number is too small to be statistically significant.

PREPARED STATEMENT OF LAWRENCE S. LEWIN

BASIC PREMISES

1. Not all of the 32 to 37 million uninsured are without access to health care.

2. But, many with insurance are underinsured or lack coverage of important benefits.

3. Many of the uninsured are the nation's most vulnerable—children, adolescents, pregnant women, homeless—for whom access to health care is among society's best investments.

4. The most serious need is not for catastrophic coverage, but for improved access to ambulatory care in the form of preventive services, primary care, chronic care management. Though cost-effective, they are often excluded from current insurance these are highly cost-effective.

5. The present employment-based plus safety net system is inherently flawed and shows signs of getting worse, not better.

6. A broad-based consensus seems to be building in support of universal access to health care including some notable new enlistees. This coalition, while tenuous can be broadened and strengthened.

7. Any solution must contribute to greater economic discipline and financing equity.

8. Given Federal fiscal constraints a phased approach—perhaps beginning with children and pregnant women.

9. Proposals must be based on careful calculations of the complex interrelationships among players to accurately assess the impact.

OVERALL CHOICES

1. Who should be covered?
   - presumably all, but not necessarily by insurance alone
   - many uninsured have access to care
   - marginal cost of providing universal access could be as low as $15-25 billion
2. What benefits should be covered?
   - ambulatory, including preventive, primary, and chronic care management may be the most important and cost-effective
   - can we develop the discipline to develop a sound but limited basic package without "Christmas treeing?"
   - can we develop means to distinguish between services needed for some but not for all?
3. What should be the public/private mix and the role of private insurance?
   - In short run, we are most likely to pursue an approach that builds on rather than replaces what we now have in place, i.e. a hybrid system with public and private ownership of both the financing and the means of production.
4. How should the financing burden be distributed?
   - reduce the burden on those offering insurance
   - avoid "free-riders" among employers, individuals, and providers
   - reduce the burden on individuals
   - face the realities of current hidden subsidies and taxes
5. How to achieve a balance between fair value (cost + quality> and fair payment?

MODALITIES OF ACCESS TO CARE

1. Private Insurance
   - Group
   - Non-Group
2. Public Insurance
   - Medicare
   - Medicaid
     - —Basic
     - —Medically Needy
   - State only
3. Publicly financed services
   - public hospitals
   - public clinics
   - private agencies receiving public funds
4. Private voluntary system
   - primarily not-for-profit hospitals

- physicians
- private agencies receiving philanthropy

INSURANCE STATUS OF NONMEDICARE POPULATION, BY INCOME, 1986

	Total	Uninsured	Medicaid	Nongroup Only	Group/ Champus/ Mil
Total (in millions)	209.9	37.4	16.4	15.3	140.8
Family income:					
$0–$14,999	50.6	18.9	13.9	4.7	13.1
15,000–29,999	57.0	9.9	1.9	4.9	40.3
30,000+	102.3	8.6	0.6	5.7	87.4

Source: Lewin/ICF Analysis of March 1987 CPS.

EXPANDED ACCESS DESIGN OPTIONS

1. Private Insurance
   a. Expand employer-based Group Insurance
      - mandate ("thou shalt"): Kennedy-Waxman
      - indifference tax ("play or pay"): Massachusetts, NLCHC
      - contribution tax (help subsidize)
      - tax credit (Oregon) or other relief for small or financially distressed firms
      - facilitate buy-in to Medicaid
      - eliminate or regulate exclusionary practices
      - facilitate/subsidize reinsurance market

   b. Subsidize and facilitate Non-Group Insurance
      - facilitate Medicaid buy-in
      - individual tax credits or increased tax deductions for self-employeds
      - expand COBRA continuation provisions
      - assigned risk pools
      - State insurance funds or products a la FEHBP
2. Public Insurance
   a. Medicare
      - decrease waiting period for SSI
      - increase incentives for enrollment in capitated plans
      - subsidize low-income participation in Rx plan

   b. Medicaid
      - expand eligibility to higher income levels, e.g. 130% of poverty for children and adolescents on a uniform, mandated basis for all states
      - create uniform Federal minimum benefits (various options)
      - further decouple from cash assistance to cover non-categorical groups such as homeless, substance abusers
      - improve provider reimbursement and remove other obstacles to improved participation
      - simplify, facilitate, promote participation
      - allow Medicaid to buy-in to approved state insurance funds for non-Medicaid eligibles with Fed/State maintenance of effort
      - fold State Medicaid programs into state insurance funds
3. Publicly Financed Programs
   - Major demonstration and new grant programs focussed on groups unlikely to benefit fully from expanded insurance (i.e. those needing help "negotiating" the system and high cost, high tech cases)
   - Expand funds for planning, coordination, construction, training for publicly funded hospitals and clinics to upgrade quality and attractiveness to population
   - special emphasis on expansion and coordination of ambulatory care.
4. Private Voluntary System
   - Focus on role of physicians in provision of charity care: assess, monitor, correct imbalances through "play or pay" mechanisms
   - Provide compensatory financing for disproportionate share providers, e.g. via funds pooling mechanisms
   - Preserve voluntary resources already in place, and stimulate more by recognizing tax exempt status for worthy institutions

PREPARED STATEMENT OF DAVID McCAMMON

My name is David McCammon. I am Vice President-Finance and Treasurer of Ford Motor Company, and with me is Jack Shelton, who is Manager of the Employee Insurance Department. I here on behalf of Ford Motor Company to testify about the important problem of providing health care for the uninsured.

Ford Motor Company shares your concern about the 31 million people in this country who do not have health insurance and the tragic consequences that result from many of these individuals not receiving needed health care. Further, we are concerned about the additional 15 million individuals who do not have adequate insurance. Like you, we hope to find a solution to this serious problem which diminishes the quality of life for those involved. Ford, like other major employers, is affected adversely by the uninsured and underinsured because providers of medical services—doctors and hospitals—often shift the cost of uncompensated care in the form of higher charges to insured patients. It is important that any program you develop for the uninsured and underinsured provide for quality care and spending controls

However, we would caution that the problem of the uninsured and underinsured is part of a much larger national problem: the failure of the present health care system to deliver quality health care at affordable prices. We believe the problem of the uninsured cannot be solved without dealing with the broader issue of increasing health care costs. The high cost of health care not only has made it impossible for many to purchase insurance but also is affecting adversely the ability of U.S. businesses to compete with foreign companies in both worldwide and domestic markets.

In 1988, U.S. health care costs were nearly $550 billion, about 11.5 percent of GNP or about $2,180 per capita. U.S. health care costs have been increasing at double digit rates for the last twenty years. Other countries with whom we compete in world-wide and domestic markets have health care costs significantly below the U.S. For example, in 1986 (the latest year foreign data are available) U.S. health care costs per capita were 41 percent higher than Canada, over 80 percent higher than Germany and France, 130 percent higher than Japan, and 170 percent higher than the United Kingdom. All of these countries provide comprehensive coverage to all their citizens.

Ford's health care cost experience has been similar to the U.S. experience of double-digit increases. In 1988, Ford's health care costs for automotive operations exceeded $1 billion and are projected to double by 1994. The proposed changes in accounting standards that will require accrual of the costs for post-retirement health benefits make these costs even higher.

Solutions to the present health system that only respond to the access problem, such as mandated employer benefits, all too often result in higher costs by creating demand for health care services without correcting the shortcomings of the supply side, such as unnecessary and inappropriate care. Once in place, government programs with inadequate controls have resulted in higher costs. For example, according to Doctor Philip Lee, chairman of the Physician Payment Review Commission, Medicare outlays for physician services tripled between 1980 and 1988, reflecting rising utilization of services per enrollees. Further, the evidence suggests that many services delivered to patients have little or no value.

In the past, the government has attempted to solve its resulting cost problems in the past by shifting costs to the private sector through reduced benefits, restricted eligibility, or partial payments to providers. The government's share of personal health expenditures has been reduced from 40 percent in 1985 to 38.6 percent in 1987, or nearly $6 billion. During this same period, private sector costs have increased from 60 percent to 61.4 percent, with businesses picking up one-third of the increase.

We urge that, in your considerations, you look at the broader issue of the need for a national health strategy that will meet the following goals: First, assure access for the uninsured; second, provide high quality care; and third, contain costs. A piecemeal solution may only increase costs and thus, prevent more Americans from receiving needed health care. We believe all the major participants—providers of health services, purchasers of care, consumers of services, and the government—need to work together to develop such a strategy.

Mr. Chairman, in closing, we commend your interest and initiative in this important and complex problem, and we stand ready to work with you in any way in which we can be helpful.

PREPARED STATEMENT OF BEVERLEY MCDONALD

Good morning. My name is Beverley McDonald and am the Executive Director of the Michigan League for Human Services. The League is a 77-year-old, statewide, citizens' organization engaged in a broad range of research, planning, education and advocacy activities to improve human services in Michigan. For the past decade, we have committed significant resources to programs and needs within the health care area, escalating these efforts over the past few years to address the growing problem of the uninsured in Michigan.

Our current activities in the area of health care for the uninsured are primarily two: analysis of the Current Population Survey (CPS) data on the scope of the problem in Michigan; and sponsorship of the Health Care Access Project, a public-private partnership in Michigan to test approaches to expanding access to medical care for the under and uninsured population, with development costs underwritten by a grant to the League from the Robert Wood Johnson Foundation.

CPS Data Analysis. Our analysis of both the 1986 and 1987 data suggests that the state holds one million uninsured persons mostly labor force participants and their dependents. (A copy of the League's report is attached.) The 1987 CPS data indicated that persons under 65 years of age suffered an uninsured rate of 11.9 percent. Interestingly enough, the academic consortium of the Michigan Task Force on Access to Health Care shows an identical uninsured rate for the under 65 population—a rate gained from their recent telephone survey in Michigan. In Michigan as elsewhere, the problem impacts disproportionately: the near poor had the highest rate of any income group—one in five were uninsured. However, to some degree the problem affected families at all income levels—16 percent of them reported at least one member uninsured. Age and gender differences emerged: one in three young men were uncovered and one in four young women. Women at sixty were twice as likely to be uninsured as their male counterparts, possibly reflecting their home-making/child-rearing function and a looser connection to the workforce. And while Medicare is working here as elsewhere to cover older Michiganians, 28 percent of them (295,000) appeared to have no private or public gap coverage and thus—from the Leagues perspective—represent a large underinsured group.

Medicaid does not appear to be working as well as it was intended—persons with income below poverty still reported an 18.7 percent uninsured rate. In families of three or more, Medicaid reached two-thirds of the under poverty population, but only one-third of those slightly above poverty and only one in ten reporting income between 125 and 149 percent of poverty.

Medicaid may not be reaching those households because the financial ceilings for participation are too low—58 percent of poverty for a family of four in Michigan—or, in the case of the parents, because of the arbitrary Federal provision which creates a big hole in the safety net by disallowing participation in two-parent households if the primary wage earner works more than 100 hours a month—regardless of the family's poverty status.

Finally, the CPS data for Michigan showed one-quarter of a million persons employed full time reporting no insurance coverage. They and their dependent children comprise more than half of this vulnerable group. Fully four of five of the uninsured either had a strong link to the workforce or were under 19 years of age. This fact supports the relevance and timeliness of major thrust of Michigan's demonstration, the Health Care Access Project.

Health Care Access Project (HCAP). While the Access Project is also to some extent helping us to define the scope of the under and uninsured problem, it is primarily aimed at testing solutions—specifically the feasibility and cost of combining ambulatory and inpatient coverage for a large group of underinsured General Assistance grant recipients and eliminating the prior authorization system for all non-emergency medical care currently in use. HCAP is also testing a financing approach—the One-Third Share Plan (OTSP)—which spreads the cost of insurance premiums across employers, employees and a subsidy fund. An overview of tie OTSP design and lessons learned from the pilot's first year is also attached.

Generally speaking, in the small business world in which OTSP is operating in Genesee and Marquette Counties, local HCAP staff have found that many of the businesses they approach carry insurance. Businesses contacted total 1,469; on average, of every 100 contacts: 41 here already carrying insurance, 19 were ineligible for

OTSP participation for other reasons, 32 declined to participate, and 8 enrolled in the one-third share financing arrangement, using an insurance plan of their choice. Project staff were only able to persuade one in five eligible businesses to come into the insurance stream, in spite of the one-third subsidy of premium costs the project supplies and the cap on the employer's contribution of one-third. All eligible businesses in Genesee County which have declined participation cite the cost factor, and nine in ten in Marquette declined for the same reason.

Participating businesses have an average age of ten years in Genesee County, five or less in Marquette. The businesses' workforce tends to be larger in the Upper Peninsula pilot site as does their enrolled group size. However, in both sites, the businesses are primarily restaurants, auto repair/parts operations, building/construction firms, retail stores and professional services (accountants, attorneys, consultants). There are other substantial differences between the urban and rural pilots: in Marquette, almost nine in ten employee enrollees are eligible for a subsidy (have wages below 200% of the poverty level), while three of four are eligible in Genesee. Half of those subsidized in Marquette are getting the maximum two-thirds subsidy, available for employees with family income below the poverty line. Only one in seven of Genesee's subsidized employees receives the maximum. The employees' wage/income and the businesses sizes significantly influence the average monthly subsidy per business—$119 in Genesee and $209 in Marquette. The share of employees who are not covered by other insurance but elect not to participate—choosing to "go bare"—also varies: 3 percent in Genesee and 11.4 percent in Marquette. More revealing in terms of employees' general interest in having health insurance, is the fact that 97 percent and 88 percent of uncovered employees in Genesee and Marquette respectively opted into the plan, contributing an average of $51 a month in Genesee and $24 in Marquette. Since the project is operating primarily in the low-wage labor market—only one in five enrollees have wages above $15,400—participation to date suggests that concern for coverage is deep enough to outweigh competing demands for these employees' discretionary funds.

Direction of Proposed Changes. One of the most difficult aspects of evaluating the many proposals and ideas—including Michigan's pilot—for expanding access to the uninsured is making a judgment on which way is "forward." Assuming that comprehensive change is not imminent and that incremental changes are much more likely to occur, such changes must be measured in terms of the direction in which they are heading: Are they moving the nation toward a goal of universal access to health care of adequate quality at an affordable cost?

To elaborate, when it is known that the target population—those currently without coverage—is primarily made up of working poor families, and solutions to access and coverage are proposed through insurance products which carry a $500 family deductible, the League would suggest that the approach will not increase access to anything but tests and inpatient hospitalization and does not represent forward movement. Nor—if indeed the working poor comprise the target group—do increased copayments help with the access problem (larger copayments representing the most commonly proposed "solution" to the cost problem which appears to be the major reason why employers do not offer coverage). It is entirely possible that in five years insured persons with the lowest out-of-pocket costs will be those in the "good," well-compensated positions, in spite of a general recognition that it is incongruous to structure a resolution to the uninsured problem in which those with the lowest paying jobs suffer the highest out-of-pocket payments to access primary and prevention services. Further, from an overall cost management perspective, it is risky public policy to design or encourage coverages for a large base of persons which primarily direct reimbursements to those areas where costs are already escalating and excess capacity exists—particularly when the approach simultaneously creates little coverage for the primary and prevention services which might function to make people less needy of proposed service areas for reimbursement such as high technology testing and inpatient hospital care.

Experience would suggest that the modern U.S. health care system may be a huge sponge which can absorb any amount of resources directed its way on medically beneficial services and procedures. The question is: What is an appropriate, affordable level of resources to channel its way? What level represents forward movement in our effort to broaden access to adequate medical care at a reasonable cost?

Many health economists believe that the nation's $450 billion annual expenditure on health care is sufficient to cover the medical needs of its 230 million citizens; they suggest the dollars have to be redirected. The League would support that view, but, in the alternative, would urge that public/private solutions to access for the uninsured which bring an infusion of new dollars into the system be directed to primary care, prevention services and low-cost therapies that work—whether the dollars come directly from the patient's pocket (25 percent of current payments) or through private insurance (31 percent). In the long run, it is the League's view that working poor families can be served by no other approach.

In conclusion, we urge policy-makers at every level to use the collective knowledge that exists on the financing and delivery of health care services, and our best sense of the target population, to create incremental steps which will move us forward toward a goal of universal access.

Thank you for inviting me to speak this morning.

Attachment.

Issue Analysis

An Update

The Uninsured Problem in Michigan:

Size and Characteristics of the Population Without Public or Private Health Care Coverage in 1987

March, 1989

Michigan League for Human Services
300 North Washington Square • Suite 401, Lansing, Michigan 48933 • (517) 487-5436

The Michigan Situation in Brief

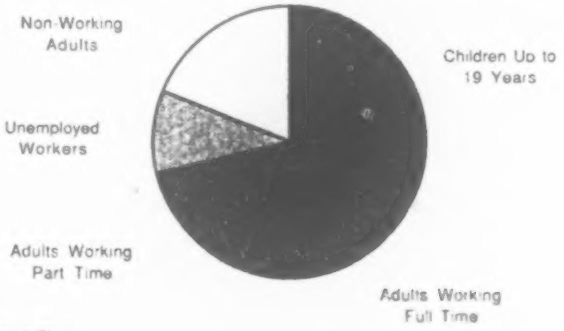
The following charts on the population without public or private health care coverage were developed using Michigan data from the March, 1987 Current Population Survey conducted by the U.S. Bureau of the Census.

In the charts which compare state and national estimates of the uninsured population, the national data were drawn from the latest such study available, a survey conducted for the National Center for Health Statistics in 1986.

A more detailed analysis of the scope of the uninsured problem in Michigan is included following the charts. For additional information related to the charts, see the text page reference below each chart.

Chart 1

Distribution of Persons Without Health Care Coverage in Michigan, 1987



(Text: pp. 1-2)

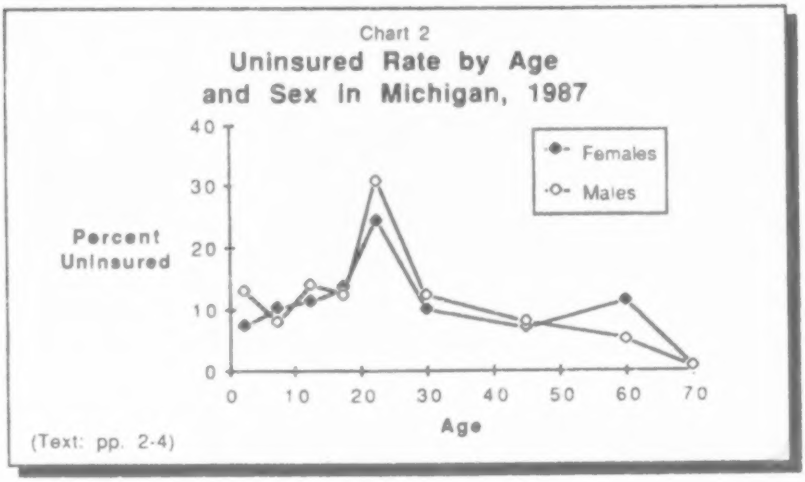


Chart 2

Uninsured Rate by Age and Sex in Michigan, 1987

(Text: pp. 2-4)

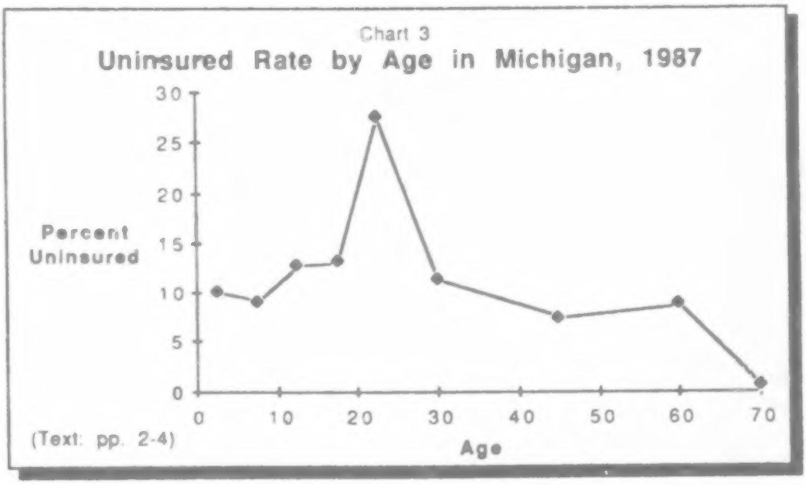


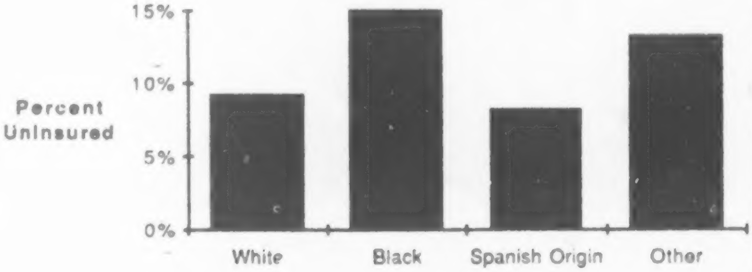
Chart 3

Uninsured Rate by Age in Michigan, 1987

(Text: pp. 2-4)

Chart 4

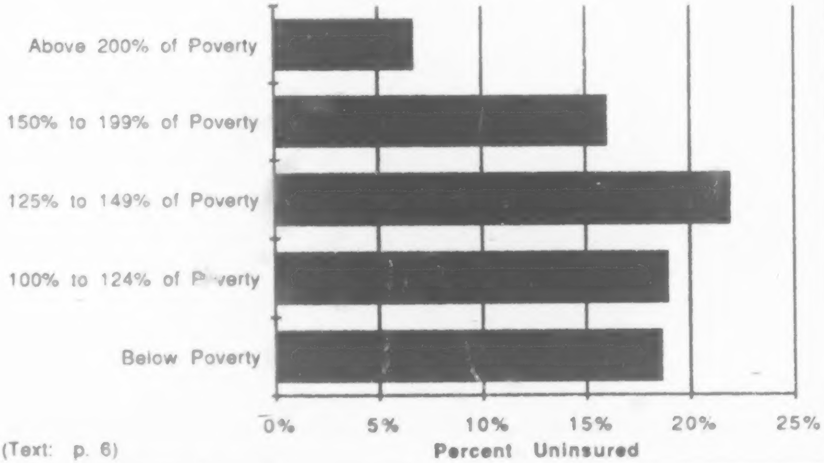
Uninsured Rate by Race in Michigan, 1987



(Text: p.4)

Chart 5

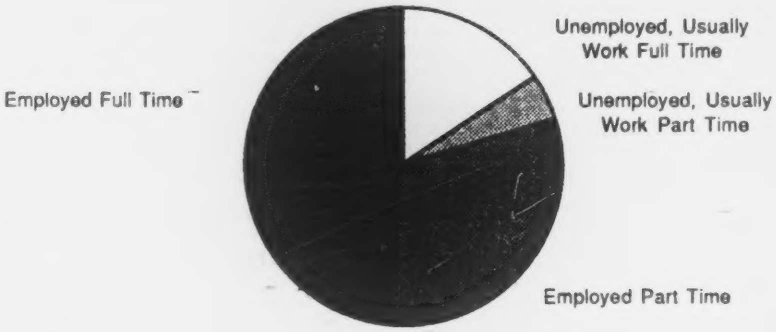
Uninsured Rate by Economic Status, 1987



(Text: p. 6)

Chart 6

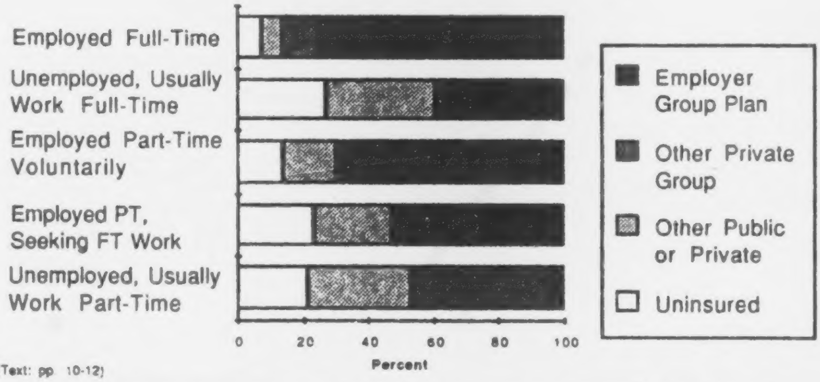
Distribution of Labor Force Participants Without Health Care Coverage in Michigan, 1987



(Text: pp. 9-10)

Chart 7

Labor Force Participants by Source of Health Coverage in Michigan, 1987



(Text: pp. 10-12)

An Update on the Uninsured Problem in Michigan

Introduction

Current public policy discussions about health care at both the state and national levels are focused on cost, utilization, quality, and access. Of these four areas, access to necessary and preventive medical care is probably the one about which the least is known. Of late, the access issue has focused on the "uninsured" problem, mainly because of the growing realization that persons without public or private health care coverage comprise a large group within the U.S. population, one estimated to include 37 million people.[1] It is feared that the lack of health care coverage may effectively prevent the uninsured group from seeking or receiving care on anything but an emergency basis.

Using Michigan data from the March 1987 Current Population Survey conducted by the U.S. Bureau of the Census, the following analysis updates the League study of January 1988, which used the 1986 survey to examine the scope of the uninsured problem in the state and the characteristics of Michigan's residents who are "in the health care cracks." The latest review of the data is more extensive, examining the relationship between economic status and lack of coverage, and regional differences in Michigan. Persons described as having "no insurance" or as "uninsured" are those who--based on the survey responses--were not covered by employer-related or other private health insurance plans or through the public programs of Medicare, Medicaid, or military service-related health care.

Summary

In 1987, it is estimated that 992,549 people in Michigan were without any kind of health care insurance--roughly 10 percent of the state's population, or one in ten persons.[2] The largest uninsured group was made up of children and young adults--almost one in three of the state's uninsured citizens were aged nineteen or younger (Table 1). Fully two in five of those without health insurance were employed, 61 percent of them full time. The other 29 percent was comprised of non-working and unemployed adults.

Table 1

SHARE OF PERSONS WITHOUT HEALTH CARE COVERAGE
BY MAJOR CATEGORIES
Michigan 1987

	Number	Percentage
Children up to 19 Years Old	307,581	31.0%
Persons Employed Full Time	243,758	24.6
Persons Employed Part Time	155,652	15.7
Unemployed Workers	101,321	10.2
Homemakers/Other Non-Employed Adults	183,967	18.5
All Persons	992,549	100.0

Disproportionate Impact

Michigan's 1987 uninsured rate varied considerably among different population groups. Persons under age 65, youngsters between 15 and 19, minorities, part-time workers, poor and "near poor" persons, and those in the state's major cities all had uninsured rates higher than the overall rate of 10.3 percent (Table 2).

For persons who had never been married, the uninsured rate was 45 percent greater, reflecting both the higher rate among youngsters aged 15 through 19 and the very large number of young adults in the 20 to 24 years age bracket with no insurance. The "near poor"--families with incomes between 100 and 149 percent of the poverty level--were twice as likely to be uninsured as the general population.

Table 2

SUMMARY
UNINSURED RATES IN MICHIGAN
BY SELECTED CATEGORIES
1987

Category	Uninsured Rate	Category	Uninsured Rate
Persons in Major Cities	13.5%	All Persons	10.3%
Persons Under the Poverty Line	18.7	All Under 65	11.9
Youngsters 15 through age 19	13.1	Minority Persons	13.9
Full-Time Employees	7.8	"Near Poor" Persons	20.3
Part-Time Employees	16.5	Homemakers/Others Non-Employed	9.2

Age Differences

The highest uninsured rate among age groups was for males between 20 and 24--30.9 percent or three times the rate of the general population. Generally, the distribution of the uninsured across age brackets seems to suggest that access to health care insurance--and through it, perhaps reasonable access to necessary medical care--may be in part dependent upon an individual's relationship to the paid labor force, or coverage through a spouse in this position. Persons between 20 and 35 years of age, who possibly had not attained sufficient work force longevity, represented almost 42 percent of the uninsured, while comprising only 26 percent of the population (Table 3). The uninsured rate then dipped to its lowest level for any non-elderly age group--7.4 percent for persons 35 to 54 years. It rises again for women over 55 but too young for Medicare, possibly reflecting the weak labor force connection of displaced homemakers--women aged 55 to 64 years of age had a 10 percent higher rate than that of the general population.

The share of Michigan's uninsured which is comprised of persons under 19 is consistent with the national experience. It does appear, however, that the state's uninsured are spread differently among other age groups: a larger share is in the 20 - 24 year-old group and a smaller share is between 25 and 54, reflecting substantially different uninsured rates in those age groups.[3] (Tables 3, 12)

Table 3

HEALTH CARE COVERAGE DISTRIBUTION AND UNINSURED RATES BY AGE AND SEX
Michigan 1987

Age	Share of State Population*	Share of All Uninsured	Uninsured Rate
0 - 4 Years	**7.2%**	**7.1%**	**10.1%**
Female	3.5	2.5	7.2
Male	3.7	4.7	13.0
5 - 9 Years	**7.0%**	**5.2%**	**9.1%**
Female	3.4	3.4	10.2
Male	3.6	2.9	8.1
10 - 14 Years	**7.5%**	**9.2%**	**12.7%**
Female	3.6	4.0	11.4
Male	3.8	5.2	13.9
15 - 19 Years	**8.1%**	**10.3%**	**13.1%**
Female	3.9	5.2	13.6
Male	4.2	5.0	12.3
20 - 24 Years	**8.4%**	**22.5%**	**27.5%**
Female	4.3	10.3	24.5
Male	4.1	12.4	30.9
25 - 34 Years	**17.8%**	**19.4%**	**11.2%**
Female	9.0	8.8	10.1
Male	8.9	10.6	12.3
35 - 54 Years	**23.4%**	**16.8%**	**7.4%**
Female	11.9	8.0	6.9
Male	11.5	8.7	7.8
55 - 64 Years	**9.0%**	**7.7%**	**8.8%**
Female	4.7	5.2	11.3
Male	4.3	2.1	5.1
Over 65 Years	**11.5%**	**0.7%**	**0.6%**
Female	6.8	0.5	0.7
Male	4.7	0.2	0.4
All Ages	**100.0%**	**100.0%**	**10.3%**
Female	51.2	47.9	9.7
Male	48.8	51.8	10.8

* Based on population estimates and 1987 projections for Michigan, Current Population Reports, Series P-25, No. 1024, U.S. Department of Commerce, Bureau of the Census.

Less than one percent of Michigan's residents over 65 are without any health care coverage, suggesting that Medicare is fulfilling its original objective. However, the Current Population Survey data do not present a clear picture of the number of "underinsured" seniors who lack public or private "wrap-around" or Medi-Gap coverage, viewed by most observers as necessary to adequate access for most seniors.

Factoring in data on the gap coverage provided by Blue Cross Blue Shield of Michigan, commercial carriers and Medicaid, this population still showed an "underinsured" rate of 28 percent. In the state in 1987, an estimated 295,000 persons over 65 years of age solely relied on the Medicare program for coverage, with no public or private program to fill the gaps.[4]

It appears that an extremely vulnerable group--even though its medical care needs can be presumed to be lower--is made up of persons 20 to 24 years of age, with male and female uninsured rates of 30.9 and 24.5 percent respectively. Overall, such individuals are almost three times as likely to be without health insurance as other state citizens. This phenomenon may reflect the loss of a parent's coverage which is not immediately replaced with job-related coverage and/or an inclination on the part of a healthy young adult earning a relatively low wage to forego coverage which requires premium cost sharing.

Minority Impact

Not all races were proportionately affected by the lack of health care coverage. Minorities (including persons of Spanish origin) taken together suffer a 35 percent higher uninsured rate than the majority (white) population (Table 4). Michigan's black citizens showed an uncovered rate almost 46 percent higher than the general population and 61 percent higher than their white counterparts--almost one in seven black persons had no public or private coverage.

Table 4

**DISTRIBUTION OF RESPONDENTS WITH NO INSURANCE
AND UNINSURED RATES, BY RACE
Michigan 1987**

	Survey Sample		With No Insurance		Uninsured Rate
	Number	Percent	Number	Percent	
All Races	6,196	100.0	635	100.0	10.3%
White	5,324	85.9	506	79.7	9.3
Black	759	12.3	114	17.9	15.0
Spanish Origin*	132	2.1	11	1.7	8.3
Other	113	1.8	15	2.4	13.3

* Also included under "White"

Marital Status Differences

Persons who were never married represented more than two-thirds of the uninsured (Table 5). One in six were without coverage, again probably reflecting the higher uninsured rate among young people 15 through 24 generally, and the one in three males aged 20 to 24 who had no coverage.

Table 5

SHARE OF RESPONDENTS WITH NO INSURANCE AND UNINSURED RATES, BY MARITAL STATUS
Michigan 1987

	Survey Sample		With No Insurance		Uninsured Rate
	Number	Percent	Number	Percent	
All	6,196	100.0	635	100.0	10.3%
Married	2,618	42.2	106	16.7	4.1
Not Married	824	13.3	95	15.0	11.5
Never Married	2,754	44.5	434	68.3	15.8

Geographical Differences

In the urban areas of the state--the "central cities" in statistical data gathering--the share of the population which is uninsured is about one-third higher than is the case in the general population (Table 6). (See table footnotes for elaboration on which cities and counties are included under table headings.) This difference would seem to reflect the relatively low number of persons covered by an employer's plan in the central cities--while less than half of urban dwellers had job-related coverage, almost three-quarters had such coverage in adjacent (out-county and suburban) areas.

Table 6

STATUS AND SOURCE OF INDIVIDUAL COVERAGE BY AREAS OF RESIDENCE*
Michigan 1987

Coverage Status/ Source	Percentage of Residents			
	Central Cities[a]	Adjacent Areas[b]	Rural[c]	All Areas
Uninsured	13.5%	8.6%	11.5%	10.3%
In Employer Group Plan	47.3	71.4	55.0	62.6
Receiving Medicaid	23.6	7.1	13.7	12.4[d]
Receiving Medicare	13.9	10.1	15.8	12.1
With Other Health Ins.	16.6	14.9	21.3	16.4

* Columns do not total 100 percent due to individuals with more than one source of coverage.

[a] Central cities data reflect the combined experience of Ann Arbor, Battle Creek, Benton Harbor, Detroit, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Muskegon, and Saginaw.

[b] Adjacent areas data reflect the combined experience of the suburbs and out county areas around the state's central cities and the extended "metropolitan" geographical area included when statistics are

(Footnotes continued on page 6)

(Footnotes continued)

collected; they include the counties of Bay, Berrien, Calhoun, Clinton, Eaton, Genesee, Ingham, Jackson, Kalamazoo, Kent, Lapeer, Livingston, Macomb, Midland, Monroe, Muskegon, Oakland, Ottawa, Saginaw, St. Clair, Shiawassee, Washtenaw, and Wayne.

c/ Rural areas data reflect the combined experience of all Michigan's counties not named in the above footnote; these rural counties are not included in the counts of the state's Primary, Metropolitan, or Consolidated Metropolitan Statistical Areas when the Current Population Surveys are undertaken by the Census Bureau.

d/ Data reflect number of persons who were receiving Medicaid benefits or had received such benefits at any point in the prior year.

Rural areas fared somewhat better than central cities in terms of the share of their overall population without coverage, but such areas also suffered a low rate of coverage in an employer's plan--55 percent compared to the state rate of 63 percent. The high rate of Medicare coverage in the rural areas (one in six received such benefits) tended to hold down the overall uninsured rate as did Medicaid coverage in the central cities.

Family Income

Not surprisingly, income levels were directly related to health care coverage: the lower the family income, the less likely the family was to have insurance (Table 7). One person in four among the state's uninsured in 1987 had family income below the federal poverty level. FN[5]. The Medicaid program--which is assumed to provide coverage to the low-income population--does not cover persons, regardless of how low their income, who are not aged, blind, disabled, or in one-parent families with dependent children. (Two-parent families qualify under limited circumstances.) This structural exclusion

Table 7

INDIVIDUAL AND FAMILY UNINSURED RATES
BY ECONOMIC STATUS
Michigan 1987

	INDIVIDUALS	FAMILIES	
FAMILY INCOME	Uninsured Rate	Share with All Members Uninsured	Share with at Least One Member Uninsured
Below Poverty Level (P.L.)	18.7%	21.7%*	25.6%
100% - 124% of P.L.	19.0	15.9	23.9
125% - 149% of P.L.	22.0	16.3	25.6
150% - 199% of P.L.	16.1	14.2	23.1
Above 200% of P.L.	6.8	3.1	12.2
All Income Levels	10.3	8.2	16.3

* Reflects large number of uninsured one person units under poverty line.

in the Medicaid program prohibiting nondisabled single individuals or childless couples under 65 years of age--or the parents in two-parent families in most cases--from participating regardless of their poverty status is considered the single biggest hole in the health care "safety net." The structure, commonly referred to as the program's "categorical" feature, is based on an assumption under serious challenge currently by the number of uninsured persons in the nation--that able-bodied adults under 65 will be employed and receiving insurance through that employment which also provides for any dependents for which they have responsibility.

Exacerbating the problem of categorical exclusions in the Medicaid program in all states, including Michigan, are the low income/asset ceilings for participation by persons who do fall within the categories. Such ceilings may be a significant contributing factor to the high uninsured rates among individuals in respondent families with income between 100 and 149 percent of the poverty level--the "near poor." Persons in this category were twice as likely to be uninsured as the rest of the state's citizens. With current protected income levels (PILs) in Michigan (the income ceilings for Medicaid participation) pegged at 58 percent of the poverty line for four persons, and 66 percent for three persons, most of the near poor population is excluded unless the family incurs a significant health care expense which, when paid, would reduce its income down to the protected income level (the "spend down" program).

A review of the Medicaid program as it served the state's poor families with children (families with three or more members in the survey were assumed to have children) showed that in 1986 and early '87, 68 percent of persons in such families under the poverty level received Medicaid at some point. The coverage rate fell to 36 percent in families with income between 100 and 124 percent of poverty, and only one in ten persons in families between 125 and 149 percent had coverage.

At almost every economic level, a substantial percentage of families had at least one member uninsured--one in four lower income families found itself in this position in 1987. One in ten families above 200 percent of poverty had at least one person uncovered, possibly reflecting the incidence of young adults without coverage who are in entry-level jobs and still living at home.

Not unexpectedly, economic status dictated not only whether one had coverage but also the source of the coverage (Table 8). Of Michigan's very poor citizens, three in five were in the Medicaid program. Of the "near poor," Medicare provided a primary source of coverage; for those slightly above poverty, one in five received Medicaid coverage, but another one in five had no coverage--underlining the impact of very low income ceilings on participation in public programs. As income levels rose, employers' group plans became the major source--if a family's income level was over 200 percent of the poverty level, its members were nine times more likely to have job-related coverage than those in very poor families.

Table 8

STATUS AND SOURCE OF INDIVIDUAL COVERAGE BY SELECTED INCOME GROUPS*
Michigan 1987

	Family Income Level			
Coverage Status/ Source	Below Poverty Level (PL)	100% - 149% of PL	150% - 199% of PL	Above 200% of PL
Uninsured	18.7%	20.3%	16.1%	6.8%
In Employer/Group Health Plan	8.2	38.0	51.6	77.6
Receiving Medicare	9.3	22.1	18.0	11.0
Receiving Medicaid	60.0	21.8	7.3	2.3
In CHAMPUS	1.1	4.5	4.2	1.9
With Other Health Ins.	13.9	17.9	26.2	15.5

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*Reflect responses from:

Individuals	902	403	545	4,346
- Families	414	199	228	1,684

NOTE: Columns do not total 100 percent due to dual coverages for some persons.

Work Force Participants' Coverage

Full-time workers in the labor force had the lowest uninsured rate (7.8 percent) of all labor force participants (Table 9). However, in spite of their overall high coverage rate, 244,000--or almost one quarter of a million of them--had no insurance. When unemployed, full-time workers were also in relatively better shape: almost three-quarters of them appeared to have their coverage extended--or to be covered under other private or public plans. Involuntary part-time workers had more than double the uninsured rate of the general population (23.5 to 10.3 percent). Overall, part-time workers maintained coverage when they were unemployed; four out of five of them had coverage, which could be a reflection of secondary earner status and coverage by another family member. Among labor force participants, the second highest coverage rate was for voluntary part-time workers; they had an uninsured rate 40 percent lower than the group of part-time workers who desired but could not obtain full-time employment.

While persons working full time in the labor force had a high insured rate, they still made up almost half of the pool of uninsured labor force participants (Table 9). Three in ten of the labor force's uninsured were working part time; one in five were unemployed.

Table 9

LACK OF HEALTH INSURANCE COVERAGE
PATTERNS AMONG MICHIGAN'S LABOR FORCE, 1987*

Employment Status	Uninsured Rate+	Number Uninsured	Share of Uninsured in Labor Force+
Employed Full Time	7.8%	243,758	48.7%
Unemployed, Usually Work Full Time	27.0	79,295	15.8
Employed Part Time, Voluntary	14.3	102,789	20.5
Employed Part Time, Involuntary	23.5	52,863	10.6
Unemployed, Usually Work Part Time	21.4	22,026	4.4
Total Labor Force	11.2	500,732	100.0

*Based on labor force participation in March 1987, U.S. Department of Labor, Bureau of Labor Statistics.

+Rates and shares based on Current Population Survey data, March 1987, U.S. Department of Commerce, Bureau of the Census.

Employer Group Plans

Closer examination of health care coverage within the labor force revealed that for many insured participants, their coverage was not employment related (Table 10). Only employed full-time workers were in an employer group plan in substantial numbers--almost three in four. One-quarter of this group also had employer group plan coverage when unemployed. The coverage rate through an employer's plan was very low for voluntary and involuntary part-time workers, 16.4 and 25.5 percent respectively. Only one in twenty unemployed part-time workers had coverage through their former employer's plan.

A substantial share of insured employed persons received that coverage under a group health plan that was not related to their place of employment. Among respondents working part time voluntarily, for every person getting job-related coverage, three others were getting coverage through another group health plan. When part-time workers became unemployed, four of ten maintained coverage through a non-job related group plan while only one in twenty had coverage through their prior employer's plan. Overall, in the employed and unemployed part-time labor force, almost half (328) respondents reported coverage in a group health plan not sponsored by their employer. The data do not answer the question of whether job-related coverage was available to respondents in the part-time labor force; coverage could have been an available benefit which was not picked up--a rational choice in cases where there was premium sharing involved and the employee already had other group coverage.

Table 10

SHARE OF LABOR FORCE PARTICIPANTS COVERED BY EMPLOYMENT-RELATED VERSUS OTHER GROUP HEALTH PLANS
Michigan 1987

Employment Status	Percentage Covered by Employer Group Health Plan	Percentage Covered by Other Private Group Health Plan
Employed Full Time	75.2%	10.9%
Unemployed, Usually Work Full Time	27.5	12.0
Employed Part Time - Voluntary	16.4	52.9
Employed Part Time - Involuntary	25.5	26.8
Unemployed, Usually Work Part Time	5.7	41.4

Premium Cost Sharing

The lack of participation by workers in an employer group plan may not always result because no plan is offered. Premium cost sharing may present a disincentive to participation, particularly for part-time and low-wage workers. The Current Population Survey showed that almost four in ten of all labor force participants covered through their employer's plan shared in the cost (Table 11). For 3 percent of employees in an employer group plan, the entire cost was borne by the employee. Since this 1987 survey showed fully one in three of the state's families with incomes under 200 percent of the poverty line (currently $20,120 for a family of three), it is possible that premium cost sharing, in addition to the prospect of out-of-pocket costs for deductibles and copayments, may be functioning to discourage participation in a substantial number of cases.

In 1987 premium cost sharing was slightly more prevalent among part-time workers--the percentage of them covered by a plan paid for fully by an employer was 8.5 points lower than that of full-time workers. Additionally, the percentage of part-time workers who paid the entire premium cost was double that of full-time workers.

Table 11

PREMIUM COST SHARING PATTERNS IN EMPLOYER GROUP HEALTH PLANS, BY EMPLOYMENT STATUS
Michigan 1987

	For Full-Time Employees	For Part-Time Employees	For All Employees
Employer Paid:			
- Entire Cost	58.9%	50.4%	58.3%
- Part of Cost	38.4	44.5	38.8
- None of Cost	2.7	5.0	2.9

Family income levels were not only strongly correlated to an individual's health care coverage through an employer's plan (in higher income families, workers were four times more likely to have this benefit), they reflected a profound difference in the degree to which employees shared in premium costs in their employer's group plan (Table 12). The rate at which the full premium was provided by the employer was 35 percent higher in more financially comfortable families than in their lower income counterparts. In almost one in ten cases of low family income, the worker had to pay the entire premium.

Table 12

INSURANCE STATUS AND COST SHARING
BY FAMILY INCOME
Michigan 1987

	FAMILY INCOME LEVEL	
	Under 200% Of Poverty Level*	Over 200% Of Poverty Level+
Uninsured Rate	18.3%	6.8%
Covered by an Employer's Plan	10.7	38.1
- Employer Paid Total Premium	44.4	60.1
- Employer Paid Part of Premium	48.0	37.3
- Employer Paid None of Premium	7.6	2.6

* Based on 838 respondent families with 1,850 members; average family size: 2.21

+ Based on 1,684 respondent families with 4,346 members; average family size: 2.58

Dependent Coverage

Coverage of the employee's spouse and children through the employer's health plan did not always occur (Table 13). Data are not available to assess whether this result was due to the exclusivity of the employer's plan or the unaffordability of the cost sharing required of the employee for dependent coverage. (In some cases a spouse and/or children may not need coverage because of participation in another plan.) Assuming that families of three or more had children in the home, this analysis distinguished them among survey respondents to determine their dependent coverage levels. In 28 percent of the families--or more than one in four--children were not covered by their parent's employer group plan.

Table 13

DEPENDENT COVERAGE PATTERNS IN EMPLOYER GROUP HEALTH PLANS
Michigan 1987

Plan Coverages	All Family Respondents In Employer Group Plan * Share With/Without Others Covered	Respondents In Families of Three or More + Share With/Without Others Covered
Spouse	22.7%	7.9%
Children	7.9	6.5
Spouse and Children	45.6	65.8
No One Else	23.7	19.8

* Data reflect 1,518 respondents in families of two or more

+ Reflective of 1,052 respondents in families of three or more

Regional Experience

The following tables (Table 14a and 14b) present an overview of the regional differences in status and source of coverage for the state's residents based on the 1987 Current Population Survey. Caution is advised on too heavy a reliance on the tables, however, since some areas with very different experiences and economic conditions had to be combined--such as Kalamazoo with Benton Harbor and Battle Creek, Grand Rapids with Muskegon, and Ann Arbor-Lansing with Jackson--to create a sample large enough on which to report. For the "Detroit CMSA" and the "Non CMSA/PMSA/MSA Counties," the universe of respondents is the largest, 2,954 and 1,153 respectively.

Major regional differences in the source of coverage can be observed: in the area of Medicaid participation, it is low in the western part of the state, high in the Flint-Saginaw area and rural areas; in Medicare participation, substantially higher in the rural areas; in non-employment related health insurance enrollment, an avenue also highly utilized in the rural areas; in job-related plan coverage, much higher in the Grand Rapids and Lansing areas; and in fully employer-paid premiums, low in the western part of the state, high in the Flint-Saginaw area and Southeast Michigan.

Table 14a

STATUS AND SOURCE OF INDIVIDUAL COVERAGE BY GEOGRAPHIC STATISTICAL AREAS Michigan 1987

Coverage Status/ Source	Percentage of Residents Entire State	Detroit CMSA *	Grand Rapids-Muskegon PMSAs+	Flint-Saginaw-Bay City-Midland PMSAs+
Uninsured	10.3%	10.0%	10.3%	10.3%
Receiving Medicaid	12.4	12.3	6.3	15.4
Receiving Medicare	12.1	11.3	13.8	11.6
With Non-Employment Related Health Ins.	16.4	16.2	14.7	13.1
In Employment-Related Group Plan	62.6	63.7	68.9	61.0
- Employer Paid All of Premium	58.4	63.0	48.3	70.1
- Employer Paid Part of Premium	38.5	34.4	48.9	28.8
- Employer Paid None of Premium	3.1	2.6	2.8	1.1

NOTE: Columns do not total 100 percent due to individuals with more than one source of coverage.

* Consolidated Metropolitan Statistical Area (CMSA) includes seven counties in Southeast Michigan with Detroit as the central city.

+ Primary Metropolitan Statistical Areas (PMSAs) attach to the cities named in the column heads; data reflect combined experience.

- Table continued next page -

Table 14b

STATUS AND SOURCE OF INDIVIDUAL COVERAGE BY GEOGRAPHIC STATISTICAL AREAS
Michigan 1987

	Percentage of Residents		
Coverage Status/ Source	Lansing-Jackson-Ann Arbor PMSAs*	Benton Harbor-Battle Creek-Kalamazoo PMSAs*	Non CMSA/ PMSA/MSA Counties +
Uninsured	9.0%	9.9%	11.5%
Receiving Medicaid	9.4	9.2	13.7
Receiving Medicare	9.0	9.4	15.8
With Non-Employment Related Health Ins.	14.3	13.3	21.3
In Employment Related Group Plan	67.9	64.3	55.0
- Employer Paid All of Premium	54.9	43.4	51.7
- Employer Paid Part of Premium	40.2	53.3	43.3
- Employer Paid None of Premium	4.9	3.3	5.0

NOTE: Columns do not total 100 percent due to individuals with more than one source of coverage.

* Primary Metropolitan Statistical Areas (PMSAs) attach to the cities named in the column heads; data reflect combined experience.

+ Reflects the combined experience of those (mainly rural) counties not included in the state's statistical areas.

Conclusion

The data reported in this analysis suggest that one out of every ten Michigan residents is without any public or private health care coverage. Perhaps more importantly, the uninsured rate is much higher among the poor, the unemployed, young people, certain minority groups, part-time workers, and single persons. Some caution is required in drawing conclusions about the precise number of uninsured individuals among the various subgroups in Michigan's population based on the 1987 Current Population Survey sample of 6,196 persons. However, comparisons with other state and national studies seem to confirm the higher prevalence of lack of health insurance among these vulnerable population groups.

In comparing Michigan's uninsured population to the national rates, the state has proportionately fewer persons in this vulnerable position. When Michigan's overall uninsured rate of 10.3 percent is compared to the 10.1 percent rate of the North Central Region of the country, however, the state's experience is less encouraging. (The Northeast Region's rate was 9.2 percent; the national rate of 13.3 percent reflected very high uninsured rates in the South and West.) (Table 15).

Available regional and national estimates for 1986 were compiled in a biennial study by the National Center for Health Statistics with a different questionnaire and procedures than those used in the Current Population Survey from which Michigan estimates on the subject were drawn. Given this limitation, it remains useful, if not conclusive, to compare Michigan's estimated rates to those nationwide.

Table 15

COMPARISON OF MICHIGAN AND U.S. UNINSURED RATES BY SELECTED CATEGORIES, 1987

	Percent Uninsured	
	Michigan	United States*
All Persons	10.3%	13.3%
All Under 65 Years	11.4	15.0
AGE		
Under 19 Years	11.2%	14.6% (under age 18)
20 to 24 Years	27.5	24.7 (18 to 24)
25 to 44 Years	9.5	14.8
45 to 64 Years	7.7	10.0
Over 65 Years	0.6	0.7
SEX		
Male	10.8%	14.3%
Female	9.7	12.4
RACE		
White	9.3%	12.4%
Black	15.0	19.6
Other	13.3	15.5

* U.S. data from 1986 biennial survey

Finally, while it may be somewhat reassuring to compare Michigan's significantly lower uninsured population rates to the nation's as a whole, it is small comfort when the state is faced with a projection that almost one million of its residents have no health care coverage and that 307,851 of its children may have restricted access to medical care as a result.

# # #

FOOTNOTES

1. Estimate based on 1985 population study by the National Council for Human Services Research (NCHSR).

2. Number of uninsured in Michigan based on the uninsured rates among demographic groups reflected in the Current Population Survey, March 1987; population projections for 1987 prepared by Michigan's Department of Management and Budget and the U.S. Bureau of the Census; and U.S. Department of Labor data on the state's employed and unemployed population in March 1987.

3. National shares of uninsured from the "National Medical Expenditure Survey," NCHSR, November 1988.

4. Estimate of underinsured persons over 65 years of age based on population estimates by the U.S. Department of Commerce, Bureau of the Census; "Blue Cross and Blue Shield of Michigan, Fact Book 1986 and 1987" and unpublished BCBSM data; and Medicaid participation rates from Assistance Payments Statistics, March 1987, Michigan Department of Social Services.

5. 1987 poverty levels were $5,500 for one person; $7,400 for two persons; $9,300 for three persons; and $11,200 for four persons.

DATA SOURCES AND NOTES

- Current Population Survey, March 1987. (Annual Demographic File), Bureau of the Census. The Michigan sample includes data on 6,196 persons. The uninsured, as used in this report, refers to persons who were not covered by Medicaid, Medicare, CHAMPUS, Employer Group Health Plans, or other health insurance. For further information on the CPS, refer to "Current Population Survey, 1987. Technical Documentation" and "Technical Paper 40, The Current Population Survey: Design and Methodology."

- "Health Care Coverage by Age, Sex, Race, and Family Income: United States, 1986," National Center for Health Statistics.

- "Population Projections for Michigan to the Year 2010, Summary Report," Michigan Department of Management and Budget.

- "Fact Book," Blue Cross and Blue Shield of Michigan, 1986 and 1987.

Special thanks to Linnea Nichols at Michigan State University's Computer Applications Programming office for her assistance in tabulating and analyzing the CPS data, and to Shari Levine, MSU student on the League's part-time staff, for her help in preparing the charts and providing technical review of the report.

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HCAP Health Care Access Project

A public-private demonstration project supported by the Robert Wood Johnson Foundation
through a grant to the Michigan League for Human Services

Status Report

THE ONE-THIRD SHARE PLAN
June 1989

Background

A major component of the Health Care Access Project is the One-Third Share Plan (OTSP) being piloted in Genesee and Marquette Counties. OTSP is designed to test a financing approach which spreads the cost of health care insurance between small employers, low wage workers, and a subsidy fund. Other than during an "open enrollment" period in late 1988 in Genesee County, local HCAP staff follow persons leaving assistance rolls for the paid workforce. If their employer does not offer health insurance and is not otherwise ineligible for OTSP, staff encourage him/her to purchase coverage for the former recipient and his/her coworkers and assume one-third of the premium costs.

For the group's employees with family income below the poverty line, no employee contribution is required--the subsidy fund picks up the remaining two-thirds of the premium cost; for employees with wages between 100 and 200 percent of the poverty line, a one-third of the premium cost contribution is required with the subsidy fund picking up the remaining one-third; for employees with wages over 200 percent of poverty, two-thirds of the premium cost is required--the subsidy fund provides no support. The employer's share of one-third does not change.

At the conclusion of the demonstration period, it is anticipated that considerably more will be known concerning: small employers' willingness and ability to offer health insurance when the cost to them is lower than is normally required; low wage workers' willingness and ability to pick up a substantial share of the premium cost, particularly in the case of higher cost family coverage; whether a one to two year subsidy will provide sufficient impetus for employers to provide coverage on their own when the subsidy is terminated; utilization and cost patterns of the previously uninsured population and the degree the which they reflect the experience of others in the same age and gender classifications; and the potential savings in public funds when persons can leave the assistance rolls for paid employment at less medical risk.

First Year's Experience

Almost one in two businesses contacted by the HCAP staff were already offering coverage, and--for most of those not offering coverage--a one-third subsidy coupled with a required one-third employee contribution could not persuade them to do so. Four of five eligible businesses declined to participate citing costs. The participating businesses' average age is 10 years in Genesee, 5 or less in Marquette. Primarily they are restaurants, auto repair/parts operations, building/construction firms, retail stores and professional services (accountants, attorneys, consultants). Urban/rural differences are substantial in the areas of business/enrolled group size, with Marquette's larger, and share of employee enrollees eligible for a two-thirds (maximum) subsidy--one in ten in Genesee and four in ten in Marquette. The enrollees' eligibility as well as the businesses' size significantly influence the average monthly subsidy per business of $119 in Genesee and $209 in Marquette. Another urban/rural difference which emerged relates to the share of enrolled businesses' employees who are not covered by other insurance but who elected not to participate: 3 percent in Genesee and 11.4 percent in Marquette.

An evaluation of OTSP is planned in the hope that its experience can inform the public debate on health care coverage; a report is anticipated in Spring 1990.

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STATUS OF HCAP ONE-THIRD SHARE PLAN
By Selected Characteristics

May 1, 1988 - April 30, 1989

COVERAGE	Genesee County	Marquette County	Total Project
Businesses Contacted	843	626	1,469
Already Providing Insurance #(%)	355 (42.1)	249 (39.8)	604 (41.1)
Ineligible - Other Reasons[1]	184 (21.8)	94 (15.0)	278 (18.9)
Eligible for OTSP #(%)	304 (36.1)	283 (45.2)	587 (39.9)
Did Not Participate[2] #(%)	233 (76.6)	243 (85.9)	476 (81.1)
Enrolled Groups			
Total	71	40	111
Average # of Employees	4.9	6.5	5.5
Average # of Contracts[3]	2.9	4.1	3.3
Employees with Other Coverage (%)	40.2	29.2	35.5
Employees Enrolled (%)	58.1	62.7	60.1
Employees Remaining Uninsured (%)[4]	1.7	8.1	4.4
Covered Individuals			
Total	393	353	746
Employees	201	163	364
Dependents	192	190	382
Average # Per Contract	2.0	2.2	2.1
Average # Per Business	5.5	8.8	6.7
Subsidized Individuals			
Total	301	307	608
Employees	151	136	287
Dependents	150	171	321
As % of All Covered Ind.	77.4	87.0	81.5
Rec'g 1/3 Subsidy #(%)	257 (85.4)	152 (49.5)	413 (67.9)
Rec'g 2/3 Subsidy #(%)	44 (14.6)	155 (50.5)	195 (32.1)
Average Monthly Subsidy	$28.13	$27.21	$27.66

	Genesee County	Marquette County	Total Project
COSTS/COST SHARING			
Total Premium Costs			
April, 1989	$28,471	$18,491	$46,962
Subsidy Offset	8,468	8,351	16,819
% Subsidy/Total	29.7	45.2	35.8
Average Cost - Contract[5]	$142	$113	$129
Average Cost - Individual	72	52	63
Annual Costs			
Total Premiums[6]	$338,352	$221,891	$560,243
Subsidy Offset	100,680	100,212	200,892
Enrolled Group Costs/Cost Sharing			
Average Monthly Premiums (4/89)	$401	$462	$423
Employer Share $(%)	134 (33.3)	154 (33.3)	141 (33.3)
Employee Share $(%)	148 (37.0)	99 (21.5)	131 (31.0)
Subsidy Offset $(%)	119 (29.7)	209 (45.2)	151 (35.7)
CHOICE OF INSURANCE/CARE SYSTEM			
Group Coverage Selection			
Prepaid/Managed Care[7]			
Health Plus (HMO)	4		4
Blue Care Network (HMO)	47	NA[8]	47
PPO	3		3
As % of All Groups	76.8		47.8
Traditional/Underwritten[7]			
BCBSM	12	11	23
Commercial Insurers	7	29	36
As % of All Groups	23.9	100.0	52.2

Source: HCAP County Staff Reports 6/22/89

Status/6/7/89/tb

ENDNOTES

1. In addition to businesses that currently or within the prior 12 months provided health insurance, others were ineligible because they did not meet participation criteria such as their workforce was only part-time; the work was seasonal/part year; no recent assistance recipients were employed, etc.

2. 100 percent of eligible businesses that did not enroll in Genesee County cited cost as the reason; 90 percent of eligible businesses in Marquette County also cited the expense, with 5 percent of them noting that the employees could not afford their share of premium costs.

3. A covered employee equals one contract; his/her dependents are covered under the same contract.

4. The difference in the share of employees who chose to "go bare" (not buy into the plan and remain uninsured) between Genesee and Marquette may relate to the affordability of a one-third cost sharing approach in an area which tends to pay lower wages such as Marquette County; the lower average wage among the pilot's enrollees in Marquette is borne out by the significant difference in the share who are eligible for a two-third's subsidy (family income below 100 percent of poverty): four in ten in Marquette and one in ten in Genesee.

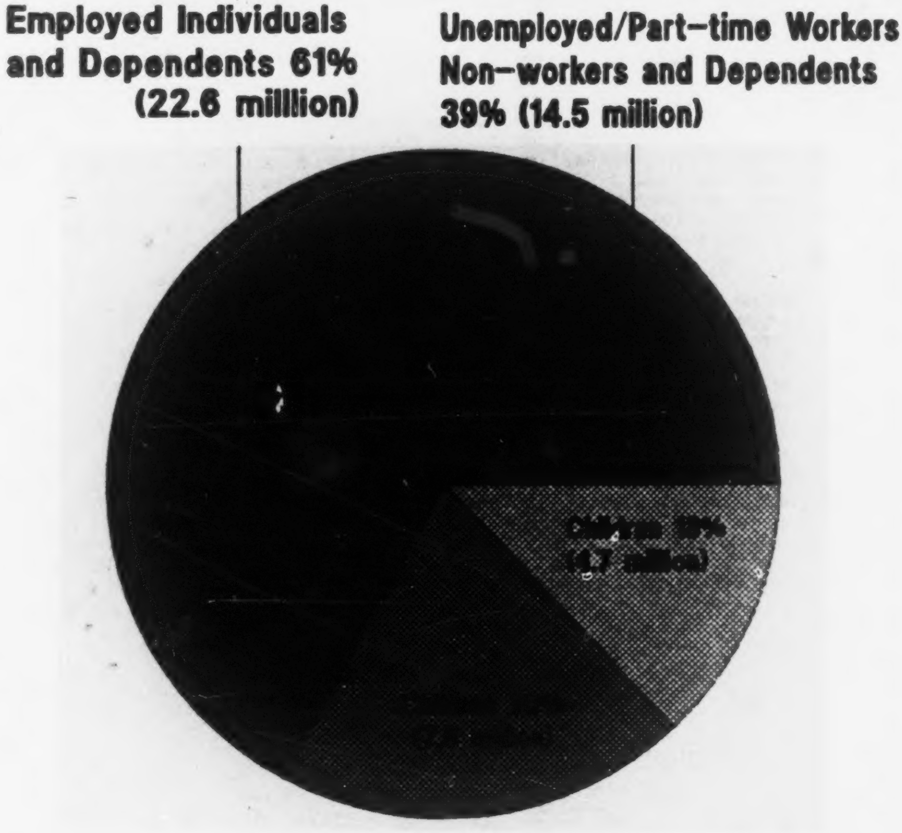
5. The average cost per individual/contract is driven by the differing rates and benefit packages provided by different carriers/delivery systems in the two counties--specifically, the percent of enrollees in Genesee in a broad benefit capitation program and the large number in Marquette with commercial insurance policies carrying a $300 family deductible; the project's policy, however, is to disallow (not provide a subsidy to) insurance products which supply few ambulatory benefits.

6. Based on April 1989 monthly costs.

7. Number of groups making selection.

8. No prepaid capitation plans exist in Marquette County. The original OTSP concept was to use a risk-sharing/care management delivery system in the demonstration which was not possible to implement in Marquette; the Oversight Committee subsequently decided to offer choices in Genesee which would include traditional insurance arrangements.

Employment Status of Uninsured Individuals, 1987



12.2 million children are uninsured (33%)

Office of Senator Donald W. Riegle, Jr.

PREPARED STATEMENT OF BONNIE POST

Mr. Chairman and Members: I'm Bonnie Post, Chair of Maine's Special Select Commission on Access to Health Care and the Executive Director of Maine Ambulatory Care Coalition, which represents Maine's community health centers. I appreciate the opportunity to appear here today to discuss Maine's efforts to insure access to health care for its uninsured and underinsured, and ways we can work together in achieving our common goal of meeting the health care needs of all our citizens.

Over 130,000 people in Maine are uninsured and countless more are underinsured. Both these groups face significant barriers to access to health care. Maine is a very rural state with little public transportation, making access to any services often difficult. We are facing shortages of many health professional, particularly physicians, physician assistants and family nurse practitioners. We have a large number of small businesses which find it extremely difficult to provide insurance for their employees. This is particularly a problem for the large number which are considered high risk, such as fishing and forestry. Governmental and bad debt and charity care shortfalls are placing heavy burdens on private insurance, resulting in skyrocketing health insurance premiums. Yet we are all working together to face these problems and have made a commitment to a major effort to improve and maintain access to health care for all our citizens.

The Special Select Commission on Access to Health Care was established by the Maine legislature in late 1987. It is an eleven member Commission, appointed by the Speaker of the House and the President of the Senate. The Commission's duties are to "investigate and make recommendations to the Governor, the Commissioner of Human Services and the Legislature to assure access to adequate health care for all citizens." The legislation further stated "the Commission's investigation shall include, but not be limited to, a review of all Medicaid options in which the State does not presently participate, and the possibilities of private and public medical insurance programs for people who cannot purchase their own insurance."

One of the Commission's early recommendations was that Maine adopt the SOBRA Medicaid options. The legislature subsequently adopted those options, providing Medicaid coverage to pregnant women and infants up to 185% of the Federal poverty level and to the elderly, disabled and children up to age 5 up to 100% of the poverty level. Presumptive eligibility, waiver of assets tests and continuous coverage for pregnant women were all also adopted. This follows a Maine tradition of providing a comprehensive Medicaid program in terms of both the services and the populations it covers. We are proud of the health care services that we have, with your assistance, provided for our most needy citizens. However, much more remained to be done.

With the assistance of a consultant firm, Lewin/ICF, the Commission conducted five seminars in the summer and fall of 1988 to determine the extent of the problem of inadequate health care in Maine and to identify potential solutions. These seminars were participatory in structure, benefiting from extensive input from a number of interested parties, including the business community; hospitals, physicians, and other provider groups; insurers; and consumers and their advocates. They served as a firm foundation for the Commissions deliberations. At the end of the seminars, the Commission adopted a number of guiding principles in designing the components of its proposed health care plan. The principles included:

- Expand equal access to appropriate and necessary care. No one should be denied access to needed medical care; this care should be received in settings that are appropriate to the nature of the medical condition.
- Assure cost-effective and affordable health care. Maine people should be able to obtain needed health services at a price they can afford and be covered by a health insurance plan which promotes appropriate use of medical care.
- Rely on broad-based financing sources. Providers, employers, the public sector and the consumers themselves all share in financing health care. Solutions should seek to avoid an imbalance in this distribution.
- Promote preventive and primary care. Solutions should assure that care is received early enough in the stage of the illness to prevent more serious health outcomes and treatment expenses.
- Maintain a mixed system of insurance and service delivery approaches and public and private sector approaches. It does little good to give people an insurance card if the health care system isn't in place to deliver the services. Solutions should build on the current mixed public-private system of insurance coverage and service capacity and not duplicate or replace it.

Following these criteria, the Commission adopted a plan for its continuing agenda to address the problem of access to health care in Maine. The plan focused on efforts to expand insurance coverage, supplemented by service delivery initiatives designed to improve access to needed services.

The Commission's plan builds on the state's existing Medicaid program by establishing a state-subsidized insurance program similar to Medicaid. This initiative, named the Maine Health Program, would enable low-income uninsured persons to obtain a Medicaid-like benefits package on a sliding scale premium related to their income. It was felt that the comprehensive benefits of Maine's Medicaid program continue to he appropriate for this low income population since out-of-pocket costs of deductibles, copayments and uncovered services such as primary care present significant barriers to access to care for those with little disposable income. It was also felt that this approach of building on the Medicaid program has several other major advantages:

1. It can benefit from the existing Medicaid infrastructure in Maine, such as benefits structure, provider and reimbursement systems, and administrative mechanisms.
2. It extends Medicaid-like coverage to other members of a family where others, such as infants or young children, are already covered through the SOBRA expansion;
3. It offers a Medicaid-like program to additional population groups, thereby potentially reducing the stigma often associated with being on Medicaid.

The Maine Health Program would have the same benefit package as the Medicaid program and would be available to persons with incomes below 150 percent of poverty with a sliding scale premium based on 3% of gross income for persons with incomes between 100 and 150 percent of poverty. The Department of Human Services would have the ability to adopt a system of assets tests appropriate for this population, taking into consideration its unique needs.

One of the guiding principles of the Commission's plan was that it supplement rather than supplant private insurance. Therefore the Maine Health Program was designed to coordinate with existing health insurance coverage. For those individuals with employer provided insurance or who are on Medicare, the Maine Health Program would be secondary, serving as a "wrap-around" for those other insurance products. It would wrap around by:

1. providing a subsidy for the enrollee's private insurance premiums when the individual's premium share exceeds 3 percent of gross income.
2. providing coverage for benefits not covered by the existing plans, such as prescription drugs;
3. providing coverage to dependents when employer-based insurance is only available to the employee; and
4. providing a subsidy for the enrollee's current copayments and deductibles when the total cost to the enrollee exceed 3% of gross income.

Some have expressed concerns that businesses may drop coverage since the Commission's plan did not include provisions mandating that businesses provide insurance for their employees. However, businesses, particularly small businesses, told us that they wanted to provide insurance for their employees and asked us to provide incentives rather than mandates for them to do so. The Commission's plan did that. It also gave low income employees the ability to pay their share of employer provided insurance, an important consideration for small employers in meeting their Section 89 obligations. The Commission felt that current market forces and Federal regulations prohibiting discrimination amongst employees in providing insurance were sufficient safeguards to prevent those companies which are currently providing health insurance from dropping coverage. I do feel however, that most who have been involved in this process believe that employer provision of health insurance will have to be closely monitored to insure that this does not occur. We have already contacted a foundation concerning the collection of baseline data to insure that this monitoring can take place.

The Maine Health Program is the foundation of the Access Commission's plan. Up to 52,000 individuals (adults and children, elderly and disabled individuals with incomes to 150% of poverty) are expected to enroll in the program during its initial year The majority of those enrollees are likely to he uninsured, but many are expected to purchase coverage to supplement their current insurance. The Commission's estimate of the cost of the Maine Health Program in its initial year is approximately $28,000,000.

The Commission fully recognized that the Maine Health Program could not meet all the needs of our citizens and that its costs could only be kept to a reasonable amount if there was employer provided insurance to "wrap-around." Therefore the Commission's plan addressed the difficulties of small businesses in providing insurance to their employees by proposing to subsidize insurance products designed to meet both their needs and the state's goals of the provision of primary care. It would do so by providing excess insurance amounting to a subsidy of costs between $25,000 and $100,000 per person. Criteria for the terms of subsidized product would be established by a special commission with input from interested parties. Those criteria include:

- minimum benefit package
- employer eligibility
- medical underwriting criteria
- minimum employer contribution to employees' premiums
- minimum length of time of employer participation

Any insurer licensed in the state who offered small group coverage would he eligible to apply as a carrier, and would negotiate the cost of the product with the State. An insurer would have to offer the coverage to all eligible businesses of less than ten employees, increasing the availability to many businesses which report having great difficulty finding carriers which will provide them with group coverage. The State would also serve as a resource to small businesses, providing information about the terms of the coverage and the participating insurance carriers. It was expected that this portion of the Commission's plan would cost approximately 2.5 million.

As a further short term incentive to small businesses the Commission proposed a three year tax credit for businesses with less than ten employees providing health insurance for the first time. The amount of the credit would approximate the value of the benefit received in the previously described subsidy program, and again the health insurance offered would have to meet specific criteria to be eligible for the credit. A more extensive credit for all businesses providing health insurance was not proposed due to both the cost and the feeling that it would simply reward those companies currently providing health insurance. It was anticipated that this more limited credit would cost approximately $700,000.

While providing insurance is a major component of assuring access to health care, it became clear to the Commission that steps have to be taken to insure that the health care service delivery system is in place and viable. Simply having an insurance card isn't enough; people who have insurance, as well as those remaining uninsured, need providers available and willing to serve them. The expanded coverage through the Maine Health Program is expected to insure a large number of uninsured people in Maine, yet many of those currently on Medicaid report difficulty getting services from certain providers.

Access to medical services is a particular problem in rural Maine. Many areas do not have adequate numbers or types of health professionals; lack of transportation prevent many people from reaching providers; and the absence of a "critical mass" of people often limits the provision of certain services. The state has a strong system of rural community health centers and its rural hospitals provide access in many areas, but funding limitations for both result in much of Maine going unserved.

To alleviate the problems of access to critical services, particularly primary care, the Commission's plan included a Community Health Program. This grant program would help fund existing local health providers or new organizations where existing providers are unwilling or unable to participate, who would directly provide or arrange access to the following services:

- Primary and preventive services
- Referral to specialty and inpatient care
- Prescription drugs
- Ancillary services
- Case finding/outreach to bring people into the system
- Health education

The grant funds would be available to community health centers, physicians and hospital outpatient departments. (Inpatient hospital services were not addressed since another Maine commission was addressing this issue). Applicants would have to meet specific criteria, including:

- Acceptance without limits of Medicaid patients and uninsured persons, including public notice of appropriate sliding fee scales.
- Linkage to WIC, nutritional counseling, and social and other support services.
- Quality assurance mechanisms to evaluate the quality and appropriateness of patient care.

- Evidence of community-wide input into the design and provision of health services to be funded under this program.

A portion of the CHP funds would also be available for health promotion and health education programs which demonstrated their ability to coordinate their services and programmatic efforts with local primary care providers and to provide a plan for follow-up care for the consumers they serve.

The precise approach for each grant would depend on available local resources and organizations and the specific needs of the community. No single model for using the grants was specified; instead grants would be designed to maximize flexibility and respond to the diverse needs of local communities while still meeting the guidelines established by the Community Health Program. The selection and amount of grant awards would be based on:

- documented health status needs;
- documented financial hardship (e.g., area unemployment);
- evidence of problems of access to health care services; and
- evidence of local commitment to the program.

These four components formed the Commission's recommendations for a first significant step that Maine could take to assure access to health care for its citizens. A report outlining the plan was presented to the legislature and the governor early this year and legislation implementing its recommendations was introduced soon thereafter. As in all legislative processes, there have been some victories and some disappointments. The greatest disappointment has been concerning those elements providing incentives to small businesses to provide health insurance. Businesses, particularly small businesses, asked that we not impose health insurance mandates since they wanted to provide insurance for their employees but found it extremely difficult to do so due to cost and availability. They asked us to provide assistance for them and, as outlined earlier, the Commission's plan did so. However organizations specifically representing small businesses gave little support for the proposal and simply did not participate in the legislative deliberations. It seemed that once there were assurances that there would not be mandates imposed, they lost interest in the' issue.

The Maine Chamber of Commerce, representing a broader spectrum of businesses was and is a very active participant in the debate concerning health care, but it felt tha a higher priority for the expenditure of funds this year was to help relieve the burden of hospital governmental and bad debt and charity care shortfall currently being passed on to other third party payors. Even though the Commissions proposal was designed to encourage the provision of private health insurance, both nonprofit and for profit insurance companies had major concerns about the proposal, as did brokers. It seemed that each was concerned that the other might gain some market advantage under it and so preferred that nothing happen. As a result of these factors, the subsidized insurance and the tax credit were both dropped from the package in the legislative committee. The Access Commission was asked, however, to consider the issue further and to submit a proposal concerning providing assistance to businesses to the next legislative session.

The remainder of the Commission's plan has fared much better, emerging from the committee essentially intact with a unanimous ought to pass report. Furthermore, in what a major paper in the state has described as a "monument to courage and compromise" it has been combined with a proposal to fund the state's Medicaid hospital shortfall and increase payments to Medicaid providers to improve access to Medicaid recipients. The entire proposal is expected to appear on the floor, ironically, today.

Funding will of course be a major barrier. We are facing the end of this yeas legislative session and a significant slowing in the sale's tax revenues have resulted in a right budget situation. However a strong coalition has made a major commitment to this package, including Maine's hospitals, physicians, insurers, labor organizations, consumer groups, and social service organizations and its Chamber of Commerce. It is recognized that new revenue will be needed and this coalition has made the commitment to support the raising of that revenue. However it seems unlikely that the full amount will be available and so difficult choices will be necessary. It has already been decided to place a cap on participants in the Maine Health Program so as place limits on future expenditures. This was a difficult move, but one that it was felt necessary.

Clearly all of us in Maine watch with great interest what this committee and this congress does concerning Medicaid and the uninsured. We are very much interested in and supportive of additional state options under Medicaid. We look forward to continuing our partnership in providing access to health care for our most needy citizens. We would be very excited about expanding that partnership to include the business community, working together to provide access to health care for Maine's working poor.

Thank you very much for your time.

Prepared Statement of Robert D. Ray and Paul G. Rogers

Mr. Chairman, members of the Committee: It is indeed a privilege for both of us to be invited to testify before the Subcommittee on Health for Families and the Uninsured. We note that the topic for these hearings is "Proposals To Provide Health Insurance for the Uninsured," a title which says much about the rapid change taking place in this critical area of public policy. Mr. Chairman, you said in calling this hearing that "High quality, affordable health care should be available for all Americans and their families." Our Commission unanimously agrees with you. That is the central feature of our vision of health care for America in the twenty-first century. But three years of close examination of the current American system has convinced us that we cannot achieve that goal with our present health care system. That goal is attainable only with a major restructuring of health care in America.

After careful study, we have concluded that our health care system is undermined by three major and overriding problems. They are rapidly rising costs, diminishing access, and serious problems in the quality and appropriateness of medical care. These problems are interrelated, they are systemic, and they are growing worse. Without systemic reforms, it is unlikely we will solve them.

As a result, we would like to address our testimony to these three interrelated and critical problems, to our proposal for comprehensive health care reform, and to the surge of support for a new, comprehensive national health policy which has grown since we issued our findings on the last day of January of this year. We would be pleased to provide for the record the Executive Summary of the Commission's report.

This hearing acknowledges the problem of the uninsured, one of the three major problems we identified. It is a cruel paradox that the most expensive health care system in the world denies access to millions of Americans because of inability to pay. This is happening at a time of rapidly expanding physician supply and while, on any one day, almost 35 percent of our hospital beds are empty. Of the 37 million uninsured, over 11 million are children, the future of our society. As many Americans are underinsured as are completely uninsured, so one out of four Americans has a serious problem of access to the health care system. These people tend not to seek care until they are quite sick, which makes them more costly to treat than they would otherwise be.

The second problem is rapidly rising costs, which have been rising at a compounded rate of 10 percent a year, reaching over $600 billion today from half a trillion just two years ago. At this rate, health care will cost the nation one trillion dollars in 1995 and $1.5 trillion by the turn of the century, when it will cost $5,551 for every man, woman, and child in the country. At that rate, by 2005. Medicare alone will exceed Social Security payments. The tremendous increase in Federal outlays has made health care a major contributor to the Federal deficit. Despite this high level of expenditures, Medicaid now covers less than half of those in need. American industry, which pays even more than the government for health care, will see massive increases in costs as well. This has led the National Association of Manufacturers to name rising health care costs as the greatest threat to American industry's economic vitality and its ability to compete. Yet, under present policies there does not seem to be any natural limit to how high health care costs can go.

The third area of major concern to the Commission is the quality of care. There are two major aspects to this problem. One is the area of the quality, appropriateness and effectiveness of care, an area where we have found serious problems. Recent studies have highlighted this concern, citing large regional variations in the use of some medical services that do not seem to be based on differences in medical need. New studies over the past several years have detailed the percentage of unnecessary and equivocal care in the use of one major procedure after another. This problem is no longer isolated to a few specialties; it is generic to the health care system. The second aspect of this problem is a lack of quality control in health care. We have insufficient means of monitoring the quality of care and fostering its improvement. In fact, the quality control systems in health care are rudimentary, yet experts in this field tell us that the infusion of quality control can yield large cost savings as well as quality improvement. Dr. Donald Berwick of Harvard has pointed out that in service industries, of which health care is one, the costs incurred due to the absence of quality control could run as high as 30 to 40 percent.

The Commission found that these three critical problems are all related to and exacerbated by the malpractice crisis, which impedes the delivery of economical, high-quality care. Malpractice litigation has driven up the cost of medical care, in some specialties at a dramatic rate. Concern over malpractice suits encourages defensive medicine, in which providers perform additional procedures, especially diagnostic ones, to protect themselves against law suits. Such procedures increase the cost of care and sometimes health risks to patients. We are convinced that our provision for the development of science-based clinical guidelines will have a major beneficial impact on the defensive medicine and malpractice problems. The atmosphere created by the malpractice crisis also corrodes the doctor-patient relationship. Convinced that the malpractice system should be reformed, the Commission proposes that the most promising current state initiatives be adopted nationwide. They include instituting strict criteria for expert witnesses in malpractice suits, strengthening standards of negligence, limiting punitive damages and contingency fees, and encouraging mediation and arbitration as alternatives to lawsuits for resolving disputes.

The report of the National Leadership Commission called for a major restructuring of the American health care system. We issued that call because our Commission had become convinced that it would not be enough simply to provide universal access to basic health services for all Americans, unless this access plan were coupled with effective cost control elements and a significant. continuing improvement in the quality of care. The Commission firmly believes that we should not provide universal access to today's system where costs are out of control and there are deep uncertainties in the quality of care. The Commission explicitly rejected a piecemeal approach and in its place developed this long-term comprehensive strategy carried out by a new public-private partnership which can control costs, provide universal access to a basic level of health services, and improve quality.

Our plan allows none of the 37 million uninsured to slip through the cracks, be they part-time workers or near-poor and struggling to get by. It calls for a new National Quality Improvement Initiative. And it calls for both public and private sector cost control measures. The key here is the basic concept of a public-private partnership. The government need not bear the burden of these changes alone. If it did, costs would only be shifted to the area where 60 percent of the bills for health care are paid—the private sector. And the private sector is already dismayed by soaring costs and unwilling to shoulder additional burdens alone.

The underlying concept of our plan is really quite simple: individuals are asked to take greater responsibility for understanding and paying for their own health care and, collectively, as a nation, for those unable to afford basic health care. We firmly believe that people place more value on something that they share in paying for. In study after study, it has been confirmed that health care services soar in volume after people are given services without sharing in their cost. Our plan asks each individual to obtain health insurance, in one of three ways: through an employer, individual purchase, or by participating in the UNAC program. Just as no American is allowed on the highway without car insurance, so no American should be allowed to go without health coverage. In setting this individual responsibility, we are also emphasizing cost-effective preventive care, such as prenatal care. The commission's system also has the advantage of building on our existing private system of health insurance and will therefore continue much of the pluralism and freedom of choice which Americans favor.

Our Universal Access, or UNAC, Plan ensures that there will be access to basic health services for all Americans. It would be funded by a small health insurance premium of two-thirds of one percent of income up to the Social Security maximum, to be paid by all employers and everyone with income over 150 percent of poverty. The Commission would have preferred providing for these services out of general revenues but did not propose this course because of the serious deficit problem. In accepting a special health insurance premium as the method of payment for everyone with inadequate health care—one out of four Americans—we believed we were turning to a widely accepted American method of financing, the dedicated fee. We built the interstate highway system using dedicated fees. We built the country's education system using such special purpose fees, and we believe we can build universal access to health care that way as well. Recent polls indicate that Americans would be willing to support earmarked fees for specific kinder, gentler initiatives in the public interest.

There are a variety of ways to do this. We picked one way, but there are other ways as well. A consumption tax could be used. The idea of an earmarked fee had the most appeal to our group. We considered the need for special measures for certain groups: part-timers, new business, and small business. We were concerned that part-time workers would not receive benefits unless they worked a certain number of hours, so our plan calls for fees to be paid in proportion to the number of hours worked. For new business, we scale in the fees over a three-year period. For small business, we propose a fee reduction of 20 percent. Any of these numbers can be reset to meet special needs, but we found these figures reasonable ways to meet these needs and costed our plan out on this basis.

The Commission believes strongly that the related problems of quality and cost must be solved if this or any other access program is to provide good and affordable health care to all Americans. Therefore, we call for a National Quality Improvement Initiative to fund the basic research to enable the medical profession to develop and continuously up-date practice guidelines for all the major procedures we do. It is widely believed by experts in the field, such as Dr. Arnold Relman, Editor-in-Chief of the *New England Journal of Medicine,* that at least 20 to 30 percent of all care provided by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary. Therefore, we have much work to do to eliminate unnecessary tests, procedures, and operations. We know how to do the research to find the answers about when a clinical procedure is clearly indicated, is unnecessary, or is equivocal. We simply lack the will to provide the funds to do the research on the 70 or so procedures that together constitute the majority of the nation's health care bill. We can save tens of billions of dollars a year by initiating a well-structured and funded quality initiative—research, development of guidelines, and their dissemination to providers, payers, and patients—as we phase in the universal access program.

It is simply no longer acceptable to adopt a major program that will give access to millions without improving the quality of care and without controlling costs. Cost control will come about in several ways. First, under our plan, everyone will pay for some part of his or her own care and most of us will share in providing care for the uninsured. That will bring an increased awareness of the high cost of care and a new concern about whether the tests, procedures, and operations being considered are really necessary. The new practice guidelines will give us better information with which to make those decisions. The most conservative estimate we could make shows savings of $22 billion a year from a decrease in the number of unnecessary operations. The UNAC program for the uninsured will purchase care more effectively than we do today, by negotiating rates with providers in a state-by-state process based on an annual budget. That, too, will hold costs down. And the private sector, where major employers are in what Uwe Reinhardt describes as a "truly surly" mood, will be able to use the practice guidelines as well and will also continue to move toward buying care more effectively, through preferred provider organizations and other methods including, if they choose, participation in the UNAC program.

It is clear to our Commission that the taxpayers, major business and labor leaders, and the government will not want to add millions of Americans, and therefore millions of services, to a system where costs are out of control. We believe there are a series of actions proposed by our report which would serve to control the rapid increases in health care costs. Just by cutting the number of unnecessary major operations in half, we could save billions of dollars as well as the time and suffering of Americans who could choose another form of treatment.

We are encouraged that other groups have come out with similar ideas and have expanded on those we developed. In the area of the quality of care, the U.S. Preventive Services Task Force, in its recent report to the Secretary of Health and Human Services, found that many tests "were of unproven effectiveness." They called for "greater selectivity in ordering tests and providing preventive services." In addition to joining our Commission in calling on patients to take greater responsibility for their own health, they found that gaps in the evidence dictate the kind of research agenda we call for. They, too, found that "in some cases, the necessary studies have never been performed," and that when studies were conducted, they often used "improper study design or systematic biases." Another major commission has just issued its report and, as anticipated and endorsed in our report, they call for the government to adopt a new method of paying physicians on the basis of a resource-based relative value scale. They also came out with a proposal, which would help control costs, to set expenditure targets as a collective incentive to physicians to slow the growth in expenditures by reducing "services of little or no benefit to patients." Using a mathematical formula, the plan calls for holding the growth in Medicare physician outlays much closer to increases in the gross national product. This plan fits easily into our National Quality Improvement Initiative as another cost control measure.

At a time when it is clear that health care costs are, as they have been for some time, a major contributor to the growth in the Federal deficit, we must work to bring the increase in health care costs down from double digit levels. We were pleased to be invited to speak before the Senate's Deficit Reduction Caucus about our cost-cutting measures. We shared our approach and the conclusions we developed with the new U.S. Bipartisan Commission on Comprehensive Health Care. It is clear to us that everyone in the Congress and i~~n the Adm~~inistration as well as in the private sector wants to be able to provide health care to all Americans, but not with the current increases in prices and volume of those services and not without visible improvements in the quality of that care.

These are concepts that are now being adopted by private industry and labor. Key organizations and individuals are calling for a new national health policy that provides comprehensive reform. Recent statements by the National Association of Manufacturers, and by the chairmen of Ford and Chrysler, reflect this. AT&T and its unions, the Communications Workers of America and the International Brotherhood of Electrical Workers, as well as Bethlehem Steel and its union, the United Steelworkers of America, have just signed pathbreaking labor-management contracts which call on the companies and unions to work with government and the private sector to achieve comprehensive national solutions along the lines we have proposed.

Other business and labor leaders, in addition to those who are members of our Commission, are coming forward to support a comprehensive solution to our three major and interconnected health problems. They would be delighted to appear before this Committee or to meet with you to discuss their concerns and the need for a comprehensive health plan for the nation. One theme that unites these very different leaders is that they perceive a growing threat to America's ability to compete due to uncontrolled health care cost ilcreases. American industry is being hit with huge annual cost increases, yet they don't believe there is a commensurate increase in quality. General Motors paid out $600 million more in health benefits in the same year that it trimmed its work force by 32,000. The $2.9 billion that GM spends on health care is the equivalent of 270,000 cars or 85,000 jobs in the auto and supplier industries.

That is a story repeated throughout American private industry. That is why we advocate a new national health policy, a comprehensive plan that is receiving growing understanding and support from organizations and leaders across the country. That is why our plan has been well-received by leaders of companies such as AT&T, DuPont, Kodak, Westinghouse, and 3M. More and more American leaders realize that the time has come to develop a comprehensive plan that will unite improvements in the quality of care with control of cost increases, so that we are able to afford universal access to health care for all Americans. If together we find the will to develop a comprehensive new plan for our nation's health care system, Mr. Chairman, we will be able to realize your goal of high quality, affordable health care for all Americans.

Prepared Statement of Carole Renaud

My name is Carole Renaud. I am a wife and mother of four children. I am here to testify about the problems my family has had getting health insurance for my two six year old boys who have Downs Syndrome.

In 1985, we were on general assistance. My husband, Gary, was going to a career training school. He had previously been through a machine training program, but could never find a job that paid enough money. So while he went looking for another job, we ended up on assistance. We made more money on assistance because not only did we receive a monthly check, we were entitled to receive food stamps and Medicaid. At this point the health insurance was important, because I was pregnant and needed medical care.

During the year we were on general assistance, Gary got his high school diploma. He really wanted to learn. Also, he was convinced that if he received additional training, we could get off welfare. He really hated being dependent on assistance. That's when he decided to enroll in a trucking school. To help pay for this training, Gary got a grant, a guaranteed student loan and some money from his parents. It really paid off because when he finished this program, the school helped to place him in a position. The first company he went to hired him. This same company put him on a training program for two years. It was like an apprenticeship to help further his education.

When he first got the job, he contacted the Department of Social Services (DSS) to notify them of his earnings. DSS informed him that they would take this information and eventually wean him off assistance. For a while, we received a monthly check, food. stamps and Medicaid. This assistance, however, became smaller and smaller as each month passed. For our family, the Medicaid was especially important because we had 4 children, including our two twins with Downs Syndrome. Kids often get sick and need medical assistance. We knew without insurance, we would have serious problems.

We began to look for health insurance about six months after we were completely weaned off DSS assistance. We were receiving no checks, no food stamps, and no Medicaid. We were in a difficult situation because as a trainee, Gary's take home pay was less than he was receiving from general assistance. He wasn't entitled to any medical benefits and there was no way we could afford to pay for it ourselves. I encouraged Gary to ask his boss for some help. When Gary did, his boss told him that he would be happy to pay for our insurance. He really thought Gary was a very good worker and wanted to do something nice for him.

A few weeks later, I received the health insurance information and the forms we were to complete. When I was filling out the forms I came across a question regarding whether we had any children who had Downs Syndrome. I thought to myself, does this really make a difference? I answered the question hoping that it wouldn't (make a difference). In addition, I had to tell them that Matt and Joe had been hospitalized once for pneumonia. Joe and Matt became sick because the furnace was out all winter. We had no heat. We were trying to keep the house warm with electric heaters. Also, we couldn't afford to move out of the house because we still weren't making enough money. Matt and Joe caught colds which later developed into pneumonia. Later, when we moved out of the house the city put a sticker on it until it was up to code. I believe that if we had been anywhere else they wouldn't have gotten sick.

I think it was a month later when we heard from the insurance company. They explained that they would cover Gary, my two other children and me, but not the twins. I remember feeling very upset and crying very hard when they sent us that letter. Gary looked at it too and became very sad. My husband doesn't become emotional when he is sad although he does get very quiet. We both didn't think this was allowed. How could an insurance company refuse to entitle two children just because they were born with a handicap. In addition to feeling mistreated, I was also very worried. Matt and Joe, the twins, tend to trip and fall because they are less coordinated. Once, while Matt was running very wobbly, he lost his balance and fell down. As a result of that accident, he is now missing a front tooth. If that had been more serious, we would have been in big financial trouble.

A year later, we tried again to find health insurance. This time we went to my husband's boss who said he would help. He contacted the insurance company and was told that we could obtain insurance for Matt and Joe, however, we would have to pay the premiums for the entire time that the rest of our family members were covered. Gary's boss was not willing to pay the entire year of premiums and we knew that we could not pay the money at this time either. Gary, who was still a trainee, wasn't making enough money. We were just trying to save so we could get out of the house. Like I said before, the house was a disaster and we really needed to get out of there.

We weren't going to give up. We continued our search for health insurance. Gary's boss also looked into changing insurance companies or changing the policy, but those attempts failed Then Joe got sick and I had to take him to the doctors. His chin was swollen and the doctor wanted to put him in the hospital. I told him I couldn't afford it so he gave me a very strong antibiotic. He also told me to check with the Association for Retarded Citizens (ARC). He said that ARC intervenes on behalf of people with Downs Syndrome and their family. In addition, his receptionist typed a letter which indicated that Joe and Matt didn't have any major medical expenses and they were, in fact, healthy boys. The doctor told me that I should show this letter to the health insurance company so they would know the kids were healthy. I followed his instructions in both instances and patiently waited in hopes that I would receive a positive response to my efforts.

First, I sent the doctor's letter to my insurance company. A few weeks later I again received a reply from them. They thanked me for the letter and told me they were sorry, but they were still unable to insure the twins. My next attempt was through the ARC Association. ARC knew that the insurance company was using outdated guidelines which have a significant impact on the eligibility requirements, so they sent the insurance company information. We were hoping that this new information, coupled with the statement from the doctor, would educate them so that they would change their decision. We were, however, once again turned down.

My husband's boss decided to make one last attempt to help. Again, he again contacted the insurance company on our behalf. This time, he was told that the twins were red-flagged. When someone is red-flagged that means they will never receive health insurance coverage. I don't know if the twins were red-flagged because I had contacted them so many times, but I did know that they would not insure my twins. That was the last time we heard from the insurance company and assistance from my husband's boss.

Joe was sick a week ago. We still haven't obtained insurance. Again my doctor was upset and told us to call the ACLU. The ACLU told us they couldn't help and told me to contact Senator Riegle. Since Riegle is the Chairman of the Subcommittee on Health for Families and the Uninsured, I thought he might be able to help me. That's when I decided to call and that's how I became involved with this hearing.

Before I finish I do want to make a statement. When Matt and Joe were born with Downs Syndrome, the doctor told us that we could give them up. If we did, they would be taken care of by the state and they would have health insurance. But we loved them and we wanted to be responsible for raising them. Now, we are being punished. We go day to day in hopes that nothing serious happens to them because we wouldn't be able to pay for health care. It's ironic that the state says I can give them up and they will take care of them, but when we say we will love them and take that responsibility, they will not help us. There should be some kind of insurance that protects us. It just doesn't seem fair. I love my kids.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Good Morning. Today, we tackle one of the most pressing problems, confronting our nation. Thirty-seven million Americans have no health insurance coverage. Tragically, 12 million of these are children, the most vulnerable members of our society. We will be exploring a variety of proposals for providing universal access to health insurance for all Americans.

My colleague Senator Mitchell—former Chairman of the Subcommittee on Health—held hearings last year examining this problem. This year, Senator Mitchell and I are continuing the work begun last year to develop legislation that provides comprehensive, affordable health care coverage for all Americans.

We have learned that the uninsured span all ages, employment statuses and income levels. Many people are falling through cracks in our employment-based system of health care. Two-thirds of the people who have no health insurance are either employed individuals or their dependents. The program for low-income people is also inadequate over one-third of uninsured persons are poor. It is important to note that close to forty percent are what we call middle and upper income individuals.

Many workers and families do not qualify because they work part-time, are between job, or work in industries such as retail or service sectors that do not provide health care coverage.

In many instances, the employer does not cover dependents of the employee. I find it particularly alarming that almost 30 percent of uninsured children live in households where the family head has employer-based coverage.

Our nation's public program, Medicaid, finances services for only certain categories of low-income persons, primarily single women with children. For example, a single woman or man, no matter how poor or sick, simply would not qualify for Medicaid. In fact, Medicaid only covers 40% of the poor.

Individuals without health insurance are less likely to obtain care. One million Americans each year are denied health care because they cannot pay for it. An additional fourteen million do not even seek care they feel they need because they know that they cannot afford it.

Shifting costs of uncompensated care to private payers drives up the cost of private health insurance. In the highly competitive health care market place, a hospital's ability to cost-shift lessens and its capacity to provide care to the medically indigent is eroded. Ultimately, the financial distress of hospitals that provide large amounts of uncompensated care threatens the quality and availability of this care.

I am very concerned that while the United States has the highest per capita health care spending rates, our system of private and public programs leaves huge gaps in coverage that indicates a radical maldistribution of resources.

We need to improve the inequities of our health care system and develop a system that provides affordable, high quality health care for all. The cost should be spread across the broadest base so that one segment of our society is not asked to bear an unfair share in solving this problem.

I first introduced a bill on the uninsured in December of 1982 and have introduced bills on this topic during the last four Congresses. I began by focusing on unemployed people without health insurance and have since broadened to more comprehensive legislation.

In Michigan, we have 1 million uninsured individuals with over 300,000 uninsured are children. Michigan has a larger proportion of unemployed adult with out health insurance and persons below the poverty level without health insurance as compared to the United States. We will hear testimony from the Michigan Governor's Task Force on activities and recommendations from my state on how to solve these problems. I also held 7 hearings across Michigan in 1987 on the problem of health care for underinsured and uninsured individuals, and we have that hearing record available to us.

I believe that the political dynamics around this issue have changed. No longer are we questioning the *merits* of solving this problem. The question before us today is *how* to accomplish the goal of universal coverage in this country.

The problem is complex; we have, however, the support of providers, insurers, unions, community and business leaders, as well as Members of Congress and former Presidents of the United States.

We all share the long-range goal of *improving* health care in this country and certainly ensuring access to health care is a major step. High quality, affordable health care should be available to every American and their families.

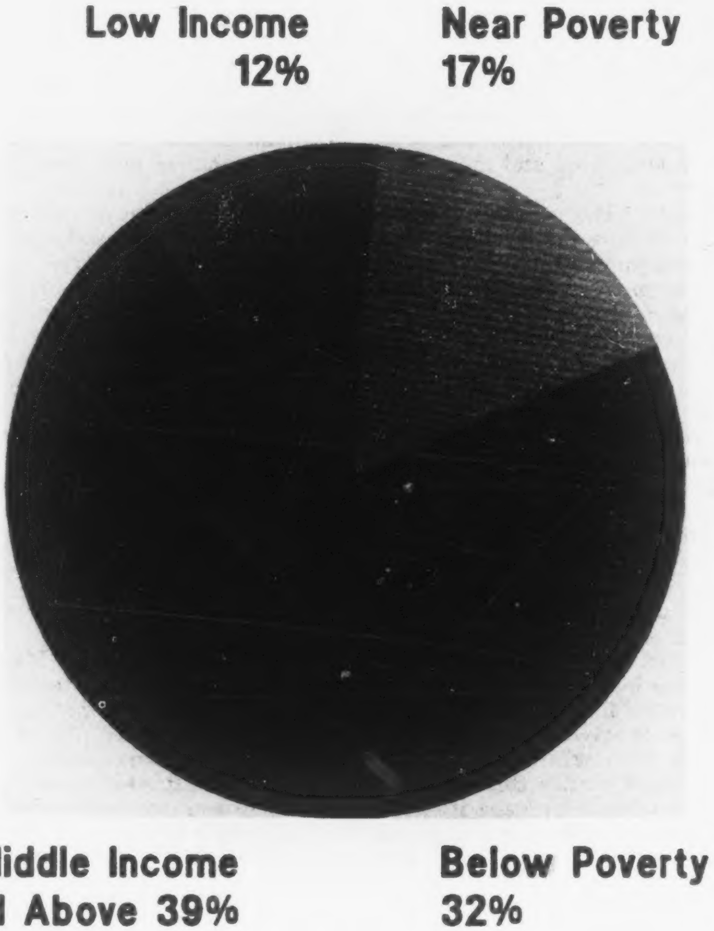
I was, however, deeply disappointed that the Administration declined my invitation to testify at this hearing. The Administration stated that they do not feel they are in the position to testify cause they have no concrete proposal and were not even sure what to say. I believe they could have at least shared their proposed plans and activities as well as discuss their ideas about expanding the Medicaid program.

This hearing and others I will hold here and in Michigan will help us to design legislation that can achieve necessary consensus and be enacted this Congress. We have several panels of witnesses with excellent proposals and ideas on how to achieve our common goals.

I am particularly pleased that my distinguished colleague from Massachusetts, a long-standing leader in Health Care, Senator Kennedy agreed to testify on his Basic Health Benefits for All Americans Act. I look forward to our two Committees working together to solve this tragic problem. We cannot, and will not let jurisdictional concerns interfere with our commitment to solve this national problem.

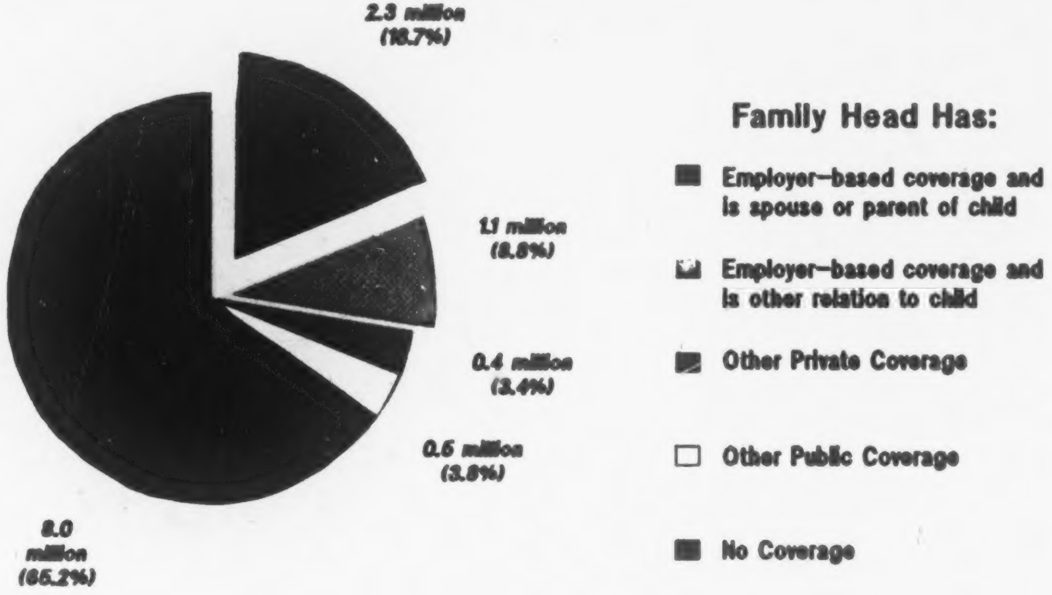
One of my priorities this Congress is to see that all Americans have access to health care when they need it. I look forward to working with other Members of this Committee to designing a system that ensures high quality, affordable health care to every American and their families.

Family Income of the Uninsured, 1987



Office of Senator Donald W. Riegle, Jr.

Children Under Age 18 Without Health Insurance by Sources of Health Insurance of the Family Head, 1987



Office of Senator Donald W. Riegle, Jr.

PREPARED STATEMENT OF CARL J. SCHRAMM

I am Carl J. Schramm, President, Health Insurance Association of America. HIAA is a trade association representing some 350 insurance companies who write approximately 40 percent of the health insurance in this country. The combined efforts of HIAA's members, the Blue Cross-Blue Shield plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Mr. Chairman, our member companies are greatly concerned about those 35 to 37 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. On behalf of HIAA, I am pleased to report a commitment among our companies to work with government in implementing effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured population; this heterogeneity requires a combination of private and public solutions.

Roughly three in ten of the uninsured are poor (with family income below 100% of the Federal poverty level); three in ten are low income (between 100% and 200% of the poverty level); and four in ten are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make formulating any strategy for a public/private solution difficult. As such we see the need to address the special needs of the various subpopulations within the 37 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured:

The first part of our recommendations involves expansion of the Medicaid program. The members of this Subcommittee know, far better than I, the intricacies and shortcomings of Medicaid eligibility, and the funding crisis that preserves them. HIAA knows that this Subcommittee has helped lead the fight and has succeeded in enacting important incremental improvements in Medicaid year after year. Because of your instrumental role in developing policy in this crucial area, I plan to spend additional time today discussing some of our latest thinking on Medicaid expansion.

A. EXPANSION OF BASIC MEDICAID COVERAGE

Ultimately we would like to see all Americans with incomes below the Federal poverty level (and with limited assets) eligible for Medicaid, regardless of family structure, age or disability status. Accomplishing this would require severing the linkage between Medicaid eligibility and cash assistance.

If available funds do not permit full coverage up to the poverty level, HIAA believes priority should be given first to younger children, next to older children and finally to other populations. Priority should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to Federal health care financing programs other than Medicaid (i.e., Medicare). This priority also reflects the critical need that children and pregnant women have for preventive services.

B. LIMITED MEDICAID BUY-IN

Individuals and families with incomes above poverty but below 150 percent of the Federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care through their state's Medicaid program.

The benefit package would include basic ambulatory services such as well-child care and immunizations, prenatal care, basic diagnostic services including laboratory tests and x-rays, primary treatment services, monitoring of chronic illness, and outpatient prescription drugs according to the state's Medicaid formulary. Inpatient services would not be covered, nor would outpatient drug or alcohol services, mental health services, cosmetic surgery, treatment of infertility, major outpatient surgical procedures, or home health care (other than maternity-related).

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection. As employer plans often incorporate a deductible in an amount which would be a relatively significant barrier for the near-poor, there should be only minimal overlap between buy-in benefits and employer-provided coverage.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection. (Assuming realistic participation rates by eligible persons, our preliminary estimate of total Federal and state costs of the buy-in is in the $1 billion range.)

A sliding scale of premiums should be developed so that, at the upper end of the income range, the charge would approximate the actuarial value of the coverage, not to exceed 15 percent of the family's income in excess of the Federal poverty level. We are developing a specific benefit package proposal that would cost about $50-$60 per month for a family of three. If five income brackets were used, for example, the suggested monthly premium charges would be as follows:

Family Income as a Percent of Poverty	Monthly Premium Charge
100–109	$6
110–119	18
120–129	30
130–139	42
140–149	54
150 + over	not eligible

Because some public subsidy is involved, eligibility would be restricted to persons with limited incomes who do not have substantial assets. However, the current Medicaid asset test should be liberalized to assure that working families would not have to impoverish themselves in order to obtain access to basic primary care. Homes, and cars of normal value, should be protected. The limit on liquid assets should be liberalized somewhat, perhaps to the $12,000 level Congress recently found acceptable for spouses of nursing home residents. A self-declaration process could be used to minimize administrative burden.

C. SPEND-DOWN

Persons not otherwise eligible for Medicaid due to higher income should become eligible for full Medicaid coverage once out-of-pocket medical expenses reduce their remaining income to the Federal poverty level.

Some coverage of last resort is needed to cover inpatient care and other large out-of-pocket expenses for the near-poor who cannot afford to purchase private insurance on their own and whose employers do not offer it or offer only very limited coverage. Ensuring such coverage of last resort should be accomplished by requiring that all states establish "spend-down" coverage at the Federal poverty level. This would establish a uniform national eligibility policy for the more limited "medically needy" option, now used by 36 states. The asset test should be adjusted to assure that the home, and cars of normal value, would be protected; but, to avoid incentives to drop private insurance, the limit on liquid assets would be left to state discretion, as it is now.

The major current problem with spend-down—it does not finance early access to primary and preventive care—is remedied by making "buy-in" available for primary, preventive and related ambulatory care.

D. "BUY-OUT"

HIAA also recommends that Medicaid eligibles who are working be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, *state Medicaid programs should be given the option of paying (and receiving federal matching funds for) the employee's share (if any) of the private insurance premium, as well as other costs.* Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage.

Under our proposal, states would have the option of "buying out" two groups. First, more working people will qualify for Medicaid as the income level is raised to the poverty level for more persons and categorical restrictions are removed. Allowing states to pay the employee's premium share for any working Medicaid eligible seems a sensible way to reduce government outlays and encourage reliance on mainstream private, rather than government, benefits.

Second, current public policy supports the concept of encouraging low-income persons to work by easing the transition from public support to self support. One component of this policy is to integrate low-income persons returning to work into mainstream, work-provided benefits while continuing to provide government support for other necessary services during a *transition period.* The most recent example of this is the Welfare Reform Act, which extends Medicaid eligibility for 12 months after a family loses cash welfare payments because of a return to work and permits states to pay the employee's share of employer-provided health insurance.

As such, states should also have the option of paying the employee's share of available group coverage during the first year after the worker loses regular eligibility for Medicaid. For the first six months after loss of regular eligibility, there would be no income limit on eligibility for this premium subsidy. For the second six months, Medicaid payment of the employee's share could continue only for workers whose family income remained less than 150 percent of the Federal poverty level. As under welfare reform, states would be allowed to charge a nominal premium during the second six months, based on the family's income as a percent of the Federal poverty level.

For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

We believe that the Federal Government can rely on states to take advantage of the "buy out" option if and only if it is financially advantageous to the state and the Federal Government (considering the benefits available under the employer plan and the charge to the employer/state to obtain them.) Since the employee's share of employer-provided coverage will usually be significantly smaller than the amount Medicaid would expect to pay to provide benefits directly, states would probably make extensive use of this option. While states should be permitted to make this decision on an employer plan-by-employer-plan basis, they must not be permitted to discriminate among individual employees.

(2) As the second piece of our four point plan, *insurers should be allowed to offer more affordable coverage, including prototype plans.* ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

Ironically, while the more than 600 state mandates do not apply to the vast majority of large employer and union plans (which are self insured) they do apply to most small employers who simply cannot afford them. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of state service and provider mandates.

HIAA will also support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

(3) *Coverage must be made available to all Americans.* This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable employer groups and uninsurable individuals.

To ensure access to affordable group coverage for all employees, a nonprofit organization should be established to reinsure high cost employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

HIAA also seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 17 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from Federal health funds the Secretary would otherwise spend in the state.

(4) *Small businesses should be given a greater incentive to provide coverage for their employees.* Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees. The 25 percent deduction which expires this year under current law, should be extended and increased, as provided in S. 494, introduced by Senator Durenberger and co-sponsored by members on both sides of the aisle.

Our proposals are designed to meet the needs of a heterogeneous uninsured population. We believe that they should be given an opportunity to work before government turns to unnecessarily onerous mandates. Our four-point plan provides a blueprint for a truly comprehensive approach to solving the problem of the uninsured. The plan stresses the sharing of responsibility between government and the private sector. In our proposal we are calling on government to assist those who cannot be expected to pay for coverage on their own. We in turn will ensure that for everyone who can afford private coverage will be available.

Thank you.

PREPARED STATEMENT OF MARTHA A. SERAFINI

Founded in 1963, The Good Neighbor Fund has helped more than 44,000 individuals. Donations from patients, family members, employees and the community are received by the Branson Health Foundation and deposited in the special account. This account is then used to pay for Hospital bills, medications and other out-of-pocket expenses-for eligible individuals. Eligibility is based upon the individual's financial and personal situation which is communicated to patient Relations via social workers, physician offices, business office personnel, and patients/families. Patient relations then assesses the requests and authorizes the assistance through the hospital business office management. Although there is unofficial limit of $5,000 per recipient, patient relations will often attempt to negotiate accounts with the institution and at times, physicians involved. This negotiation has often been on behalf of patients in vocational rehabilitation, who may receive some money from the state to cover outstanding accounts, but cannot obtain coverage for the entire amount due. These individuals for the most part have no inpatient health care coverage and no resources to pay for their medical needs, but are attempting to get into the mainstream through vocational rehabilitation. Negotiating for these and other individuals allows the fund to make an impact disproportionate to its relatively small assets.

Although a large part of the fund pays hospital bills, an equally critical need is medication assistance for patients with no other way to obtain it. This assistance is often crucial in allowing a patient to be discharged from the hospital and/or preventing another hospitalization due to inability to pay for medications. At times, this assistance is only needed to fill a short term need, allowing the patient to take the necessary medication and still meet basic living expenses. Unfortunately, there are many instances when the assistance simply buys the patient time. This is especially true of patients with heart ailments and other chronic conditions that may not be considered serious enough to medically "disable" them, allowing them to obtain appropriate lone term medication assistance. These individuals may be forced to make monthly choices of paying for groceries or paying for medications, and usually eventually end up being re-admitted due to their inability to buy the medications. These patients are referred to the patient relations staff who can provide immediate assessment and assistance via the hospital pharmacy.

Having worked with the fund for a number of years, I have seen the type an number of requests change drastically. For the first time since my involvement with the fund approximately 8 years ago, we have been forced to implement 2 moratoriums on requests fro assistance with hospital accounts due to the increases in these requests. In addition to the moratoriums, we are now forced to refuse requests based upon the fund's ability to provide assistance rather than the eligibility of those asking for help.

The numbers of these "falling through the cracks" of current programs for medical assistance are no longer only the indigent. We now see working poor families, classified as ineligible for assistance, yet with no resources to pay for health care.These families are often headed by women, working in low paying jobs with little or no insurance benefits. (See enclosure No. 1—"Judy".)

Another reoccurring situation involves those not sick enough to be classified as disabled, but not well enough to obtain and hold a job. (See enclosure No. 2.)

The Good Neighbor Fund has been an incredible support to those Bronson Hospital patients in need. Unfortunately, it has become a "band-aid on brain hemorrhage." There are so many individuals who have poor or no access to quality health care due to their inability to pay. Hospitals are being asked to absorb more and more of these cases and at the same time, get less and less reimbursement for those lucky enough to be eligible for assistance. Programs such as The Good Neighbor Fund can supplement public or private assistance, but cannot impact the current and-future health care needs of this growing population.

Enclosure.

Case example (enclosure #1)

HELP FOR THE TEMPORARILY HELPLESS
THE GOOD NEIGHBOR FUND

It was 3:30 a.m. when Judy awoke. There was a warm dampness about her. In a moment the young, single mother was panic-stricken with the realization that her bed was covered with blood. A latent hormonal imbalance had thrown her system into chaos.

MARTHA SERAFINI ADMINISTERS THE GOOD NEIGHBOR FUND

She jumped up, but rising so suddenly made her faint and she collapsed onto the floor. When consciousness returned, she moved more cautiously—physically weak, confused, cold, frightened, and alone.

Afraid to walk, she pulled herself through the house on her elbows, trying to reach the telephone. She would call her parents. They would know what to do. They would help care for two-year-old Nicole and one-year-old Levi, her two young children. They would help her. She made the call, and then passed out on the couch.

It didn't take long for her parents to arrive. Judy thinks they made the 15-mile trip "in about four minutes." Just as quickly, they put her into the car and drove her to the Trauma and Emergency Center at Bronson Methodist Hospital.

"Don't admit me. I can't afford it."

A physician was immediately at Judy's side. Seeing her stained clothing and the pallor of her face, the doctor knew there was little time to spare. The blood loss was no doubt taxing the patient's heart. She would have to act fast to prevent cardiac arrest. She shouted orders to the emergency room team, tried to reassure Judy, and told her that treatment would begin just as soon as Judy gave permission.

The commotion in the busy emergency room added confusion to the weakness she already felt, yet a gnawing, ever-present worry remained foremost in her mind: *she could not afford this treatment.* Judy blurted out, "Just give me a drug and let me go home. I've got two kids to take care of. I don't have any money. I don't want to stay in a hospital, and I can't afford to be off work."

"That was scary," Judy says now. "You always read about people in magazines who have these $30,000 hospital bills, and there's no way to pay for it. It's going to come out of their Social Security, and for the rest of their lives they'll be paying on the bills. That's why I said, 'I don't want you to admit me in the hospital. I don't know what the bill's going to come to, but if it's more than five dollars I can't afford it.'"

Her mother pleaded with Judy to accept care, but it was the doctor who finally convinced her, saying sternly, "If you don't let us admit you, you're going to die. And, you're not going to be able to take care of your kids when you're dead!" That was the argument she couldn't fight.

The doctor went on to tell Judy that she should not worry about expenses at a time like this, saying there were other ways to handle them and that the hospital does not turn anyone away. Although she didn't really expect help with her medical bills, Judy consented to treatment. She was given massive blood transfusions, intensive care, and medication to correct the hormonal problem.

Judy's mother visited the next day and said she couldn't believe how much better she looked. When Judy looked in the mirror it was as if she had developed a healthy glow overnight. The difference in her color was that great.

Telling her Story

Another visitor came that afternoon. Patient Relations Coordinator Martha Serafini, who administers the Good Neighbor Fund. Judy was feeling strong enough to begin to worry about the expense of her 3-day hospital stay, especially since she knew she would probably be away from work for at least a week. She told Martha about working two jobs to pay her rent and to keep food on the table.

During the day she worked for a bill collection firm—a job which gave her a daily headache, as she empathized with each prospect she faced. Two nights a week she was the bookkeeper and auditor for a local motel. The two positions netted her a grand total of $163 per week, nearly half of which went to a friend who cared for her children.

Ninety-three dollars a week was hardly enough to pay the rent, much less medical bills, but it was enough to disqualify Judy from governmental assistance programs. She was one of the growing number of unfortunate victims in a decade of belt-tightening. She "fell through the cracks" of the system, as Martha describes it.

Goal-oriented, hard-working, and dedicated to self-sufficiency, Judy was frustrated and embarrassed about being helpless to deal with her situation. Caught up in a confusion of complex guidelines and changing federal priorities, Judy thought she had nowhere to turn.

The Good Neighbor Fund Responds

Fortunately, Judy was wrong. Martha explained to her how the Good Neighbor Fund works. "She said it was for small, one-time, emergency situations for low-income patients," Judy remembers. "I filled out the forms that they wanted, and she said to call her back if I didn't hear whether I qualified. So I was chewing on my nails, sitting on pins and needles, until the deadline was up.

"I called Martha, and she said that the bill had been taken care of and I had nothing to worry about. So I don't know how much it was, or what it covered, but I didn't have to pay anything for the time I was in the hospital. So I assume that it covered the lab work and the hospital stay… I didn't see any of the bills… It was just taken care of."

There was more than money involved. Judy says that Martha came to see her while she was in the hospital, asking how she was doing, answering her questions, and telling her not to worry.

How the Good Neighbor Fund Works

Founded in 1963, the Good Neighbor Fund has helped more than 44,000 individuals. Continued community support over the past 25 years has made this possible. Contributions are welcome and, when received by the Bronson Health Foundation, are deposited in a special account administered with specific guidelines.

Judy's situation is one of the few in which medical expenses are covered. Most often, grants are for other needs related to a hospitalization. Although there is an unofficial limit of $5,000 per recipient, most of the distributions are for $1,000 or less, to people for whom that amount is a staggering figure. To be considered, the patient must be in a low-income bracket, have a medical problem which requires one-time treatment, and be ineligible for any other government or philanthropic aid.

Helping All Who Need It

By limiting the amount of each grant, the Good Neighbor Fund can touch more lives. It also helps to maintain the fund's financial integrity. Martha notes that the fund cannot respond to needs which are too great or ongoing in nature. "For example, if someone has a very large bill, on the order of $25,000, the amount we would offer would not make an appreciable difference, so we save the fund for cases in which it can do the most good," she says. "In another case, the need may be $4,000 this month, but next month the same person may owe $3,500 more, and so on. Although each amount falls within our guidelines, it would be a poor use of resources. If a medical bill is that large or ongoing, there should be another agency better suited to help out," she added.

Martha says she only remembers one request which met the criteria but was denied. It occurred when a college senior took a calculated risk allowing her medical insurance to lapse—just before she needed it. A determination was made that it would be better for the individual to live with her decision, especially since her degree would soon lead to a well-paying job. Other than that one case, the fund has been able to help every person who met the financial-need guidelines.

Others Who Have Been Helped

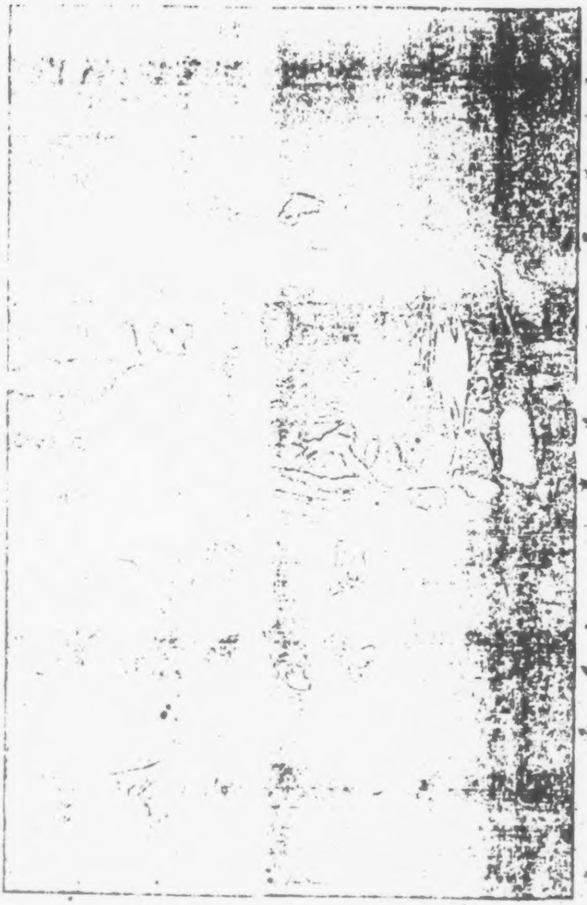
When we asked Martha to suggest a case history for use in illustrating the work of the Good Neighbor Fund, she pulled out a large file and said there is no "typical" recipient. In one case a security guard was struggling to pay $14 a month on an outstanding balance of $800. He might have been able to keep that up for nearly five years, but the patient relations staff decided that the long-term debt was too debilitating for him.

In another instance, a young couple with a child in the Neonatal Intensive Care Unit faced a bill for over $2,500. The mother was barely making the minimum wage as a waitress and the father was self-employed, doing only a little better. They had health insurance, but the company denied payment. After prolonged litigation, they agreed upon a settlement of $1,000, thinking a government agency would help with the rest. Unfortunately, when they applied to Medicaid and Social Services, they were told that their claim was not made "in a timely fashion," and therefore could not be considered for payment. The Good Neighbor Fund stepped in to cover the remaining $1,500.

In addition to providing direct payments to the hospital, doctors, and other care providers, and incidental expenses as necessary, the Good Neighbor Fund coordinators also help direct patients and their families to other aid sources. When aid has been exhausted, they negotiate charges with the various health-related creditors.

Sometimes doctors will reduce or forgive their charges altogether. The hospital's business office management will also work with fund coordinators. The end result is that the Good Neighbor Fund makes an impact disproportionate to its relatively small assets.

Judy was anxious to tell us her story, saying, "Somebody ought to tell everybody about the Good Neighbor Fund. They [contributors] really deserve a pat on the back."



[illegible] AT A GLANCE

☐ [illegible] families
☐ [illegible] expenses only
☐ [illegible] of $5,000 each
☐ [illegible] exhausted

Case example (enclosure #2)

Mr. Duffy was three weeks into his new job when he experienced a heart attack. He was rushed to the hospital and treated, with a resulting hospital bill of over $13,000. Because he had not been on the job for a long enough period of time, he had no health insurance. His wife works part time at a local discount store making $3.65 per hour.

Presently, Mr. Duffy cannot be disabled by his physicians, who feel he will eventually be able to work. Mr. Duffy has been a roofer, which further hampers employment opportunities. Mr. and Mrs. Duffy have lost their mobile home and are living with relatives, with no possibilities for assistance.

Martha A. Serafini
5256 Manana
Kalamazoo, Michigan 49004

TITLE:

Patient Relations Specialist, Bronson Methodist Hospital

CURRENT DUTIES:

Provide formalized complaint documentation, investigation and response; provide assessment/authorization of hospital funds for patient/family assistance; provide early alert and liaison role in risk management situations; assist patient/family with inquiries of resources, concerns and unmet needs. provide institution with information regarding consumer perceptions of services.

HISTORICAL ROLE WITH BRONSON:

Employed with Bronson Hospital since 1973, functioning in the patient relations role since 1979.

PROFESSIONAL MEMBERSHIPS:

National Society for Patient Representation and Consumer Affairs

Michigan Society of Patient Representatives

Michigan Association of School Boards

COMMUNITY ACTIVITIES:

School Board Member, Parchment School District

Board Member, Friends of Children with Cancer

Migrant Ministry

Appalachian Christmas Project

Education:

Western Michigan University, December 1989 graduate. Major: Sociology; Minor: Social Work

COMMUNICATIONS

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association is writing to express its views concerning the important issue of providing adequate health insurance coverage for the many Americans who are uninsured or underinsured. We request that this statement be included in the record of the Subcommittee's June 19, 1989 hearing.

CHARACTERISTICS OF THE UNINSURED

The number of uninsured Americans has increased significantly since the late 1970s when about 26 million people were uninsured. During the recession of the early 1980s, the number of uninsured increased dramatically, reaching about 34 million by 1983. Since that time there has been some dispute over the absolute number of uninsured, with estimates ranging from 31 to 37 million depending on the population base used. The most recent data from the National Medical Expenditure Survey (NMES) of the National Center for Health Services Research and Health Care Technology indicates that, in 1987, 36.5 million (17.4%) of the under-65 population were uninsured, an increase of 38% from 1977.

Extending health Insurance coverage to the currently uninsured requires an understanding of the group's characteristics. The uninsured are a heterogeneous group. According to the NMES survey, the employed uninsured, with their dependents, accounted for 75% to 80% (about 26 million) of the uninsured population. Of the 26 million employed uninsured, 85% (21.7 million) worked for firms with fewer than 100 employees, and 48% (12.4 million) worked for firms with fewer than 10 employees.

Many of the employed uninsured are low wage earners. About one-third earn $10,000 or less annually. Approximately 30% of the uninsured have incomes below the Federal poverty level and another 30% have incomes between 100% and 200% of the poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable." These persons are either unable to obtain health insurance coverage or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack *adequate* health insurance coverage. Thus, while these persons have health insurance, they may still be financially vulnerable and may lack access to necessary health care services.

Studies already indicate that the uninsured use less medical care than the insured, and that they are less likely to seek care when ill. We are concerned that with the U.S. health care system becoming more competitive and cost-conscious, the uninsured will experience increased difficulty in finding access to necessary health care services.

REASONS FOR INCREASE IN NUMBER OF UNINSURED

The rise in the uninsured population is most often attributed to (1) Medicaid's failure to keep pace with the increase in the number of people in poverty, and (2) high unemployment from 1980 to 1982 followed by shifts in employment away from manufacturing to relatively low-paying service-sector jobs, and increasing numbers of part-time workers.

While the number of persons on Medicaid has increased during the 1980s, the number of persons below the poverty level has risen even more sharply. As a result, Medicaid, which initially covered over 60% of the poor, now covers only about 40% of this group.

The number of Americans who are covered by employer-based insurance increased dramatically during the period from 1945 to 1979. While there has been a significant increase in the number of employed persons since 1980, the number of workers and dependents covered by employer-based health insurance has remained constant at about 137 million people. A reason frequently given for the increasing number of employed uninsured has been the major shift away from manufacturing jobs with high rates of employer-provided insurance and into the service and retail sales sectors that have lower rates of employer-provided insurance. There has also been a growth in the number of small businesses which frequently do not provide health insurance. In addition, there has been increased use of part-time workers who generally do not receive health insurance.

A final reason cited for the increase in the number of the uninsured is that fewer spouses and dependent children are being covered by employer health plans. This is because some plans do not offer such coverage while others make it too costly for many workers to afford. In addition, a growing number of workers who are offered and can afford coverage simply decline it.

The major reason that some businesses do not provide health insurance appears to be the cost of such coverage. The over 600 state mandated benefit laws are an important factor in increasing the cost of coverage. The cost of coverage is particularly high for small businesses which tend to be less profitable and face large administrative costs. In addition, small businesses that have employees in poor health may not be able to purchase coverage at any price.

AMA PROPOSALS

Because no single approach would adequately address the health care needs of all of the uninsured and underinsured, the AMA has developed a number of state and Federal legislative proposals for extending adequate health insurance coverage to unprotected individuals. The proposals involve providing coverage through the private sector for the uninsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. These proposals are described below.

Coverage for the Employed Uninsured

The AMA supports the concept of requiring employers to provide health insurance coverage within the private sector for all full-time employees. Requiring employers to provide health insurance would ensure coverage for the largest group of the uninsured, the employed uninsured. In our view, this requirement should be phased-in over several years and initially should apply only to larger employers. In addition, it is essential that tax credits or other tax benefits be provided for new and small businesses to avoid adverse effects on employers.

Medicaid Reform

About 11 million of the approximately 37 million uninsured persons have incomes below the Federal poverty level. While the AMA, in general, prefers that health insurance coverage be provided through the private sector rather than through an expansion of government coverage, the Association believes strongly that Federal and state governments have a legitimate role in assuring access to medical care for persons with incomes below the poverty level.

It is well documented that the Medicaid program is fraught with problems and inequities. Problems with Medicaid include: lack of coverage for about 60% of individuals with incomes below the poverty level; wide variation in eligibility criteria and benefits from state to state; and grossly inadequate physician and hospital reimbursement levels which restrict access to care. The AMA believes strongly that the Medicaid program should be reformed to: (1) create a basic national standard of uniform eligibility for all persons below the Federal poverty level (adjusted by state per capita income factors); (2) create basic national standards of uniform minimum adequate benefits; (3) eliminate existing categorical eligibility requirements; and (4) provide adequate physician and hospital reimbursement to assure broad access to care.

The AMA is aware that implementation of the above reforms would result in a significant expansion in the number of Medicaid beneficiaries and in the amount of state and Federal spending under the Medicaid program. In our view, however, no other solution would adequately address the health care needs of the uninsured with incomes below the poverty level.

State Risk Pools

The AMA supports the enactment of state legislation that would establish a risk pool program to provide health insurance coverage both for the medically uninsurable and for medically standard risks who cannot afford individual coverage, but who could purchase coverage at near standard group rates with or without financial assistance. (Fifteen states already have enacted risk pool legislation to create health associations that sell policies to high-risk, uninsurable individuals. These pools use a variety of mechanisms to make coverage available while spreading the cost of covering the medically uninsurable over a large population.) The pool would provide a specified level of adequate benefits and would set premiums at a suggested level of no less than 110% or more than 125% of the average premium for comparable group coverage. States should provide publicly funded vouchers on a sliding scale to help persons with incomes between 100% and 150% of the poverty level pay the premium for pool coverage. Persons with incomes between 150% and 200% of the poverty level also would be eligible to purchase pool coverage at their own expense.

It is likely that the costs of risk pool coverage would not be met totally through enrollee premiums. In that event, risk pool costs in excess of premium Income should be spread as widely as possible. The AMA believes strongly that all health care underwriting entities in the state, including commercial carriers, non-profit medical service plans, health maintenance organizations, and self-insured plans, should be required to participate in the risk pool. By having all health insurance carriers participate, the pool would be assured a financial base sufficient to support the program and to achieve a fair sharing of the risks. Unfortunately, states currently are prohibited by the Employee Retirement Income Security Act (ERISA) from requiring that self-funded employee benefit plans participate in state risk pools. This prohibition creates strong barriers to effective operation of state risk pools since self-insured plans write over half of the employee group health insurance business.

In order to achieve broad participation in state risk pools, the AMA has developed draft Federal legislation that would amend ERISA so that states would regulate self-insured plans in the same manner that other health insurance plans are regulated. Self-insured plans would thus have to participate in state risk pools. The AMA also has developed draft federal legislation that would make available the deductibility of employer health insurance premiums only to employers who purchase group health insurance coverage from an entity that participates in the risk pools. If the employer is self-insured, it must participate in the risk pool directly. A copy of each of these draft bills is attached to our statement. We urge that this Committee and Congress give these bills careful consideration.

The AMA supports the use of state tax revenues as an alternative to assessing the carriers participating in the pools for any excess pool costs over premium income. Using state tax revenues would spread the pool costs over all state taxpayers rather than over only the policy-holders of participating carriers.

Temporary Extension of Coverage

Workers who are laid-off should have the opportunity to maintain employment-based health insurance for at least several months after their termination. As a result, the Association supported the provisions in P.L. 99-272 that require employers to make group health insurance available for terminated workers and their dependents at the worker's sole expense for an additional 18 months after the lay-off. In addition, the Association supports requiring employers to offer to continue health coverage for laid-off workers and their dependents for up to four months after the lay-off, with the employer and ex-employee continuing to pay the same percentage of the premium they had paid before the lay-off. Enactment of such legislation would encourage laid-off employees to continue their health insurance coverage in their former employer's group health plan because they would not have to pay the full premium.

Open Enrollment Period

The AMA supports legislation that would require an employer's group health plan to provide an open enrollment period of at least 60 days for spouses of unemployed workers. In some two-income families, only one spouse may be enrolled in a group health plan. Currently, if that spouse becomes unemployed, the whole family would be without health insurance coverage. Enactment of mandated open enrollment legislation would appropriately address this situation.

Deduction for Self-Employed Individuals

Currently, self-employed owners of unincorporated businesses can deduct as a business expense only 25% of the cost of premiums for their own health coverage. Owners of incorporated businesses can take a 100% business deduction for their own health insurance premiums if they provide coverage for their employees.

The AMA supports legislation that would allow all self-employed individuals to take a 100% business deduction for group health plan contributions paid for their own health insurance if they provide adequate health insurance coverage for their employees. Permitting self-employed individuals to take a full business deduction for their own group health plan contributions would encourage them to offer health insurance coverage to their employees and would create parity with incorporated businesses.

Encouraging Formation of Multiple Employer Trusts

The Federal Government should encourage the increased formation of Multiple Employer Trusts (METs). METs allow small employers to combine their buying power and spread their risks over a larger employee group. Encouragement of METs should result in more small employers being able to afford to either directly offer or to purchase adequate health insurance coverage for their employees. The AMA recognizes that those states currently not regulating the fiscal solvency of METs would need to enact appropriate legislation. In addition, a mechanism would be needed to ensure that METs purchase or provide adequate benefits. In our view, legislation should be enacted that would provide such a mechanism by amending the Federal tax code to make the provision of adequate benefits a condition for an employer to deduct the cost of group health insurance premiums as a business expense.

Coverage for the Otherwise Uncovered—Establishment of State Indigent Care Funds

For those who would still need care but would not have adequate coverage, the AMA supports the establishment of state indigent care funds. The funds would pay health care providers in proportion to the amount of uncompensated care they render and would be financed from general revenues.

CONCLUSION

The AMA is very concerned about the fact that millions of Americans lack adequate health insurance coverage. The severity of the problem of the uninsured and underinsured makes further Federal and state government action necessary. We have developed a number of proposals for extending adequate health insurance protection to the uninsured and the underinsured. Our proposals involve providing coverage through the private sector for the uninsured and underinsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. We urge the Committee to give careful consideration to these proposals.

Attachment.

TAX CODE AMENDMENTS: DEDUCTION ALLOWED FOR CERTAIN HEALTH INSURANCE PREMIUMS; TYING BUSINESS DEDUCTION TO RISK POOL PARTICIPATION

The purpose of this bill is to encourage the establishment in each state of a risk pooling program to provide health insurance coverage to both those who are unable to obtain such coverage because of medical considerations, and those who are medically standard risks and could afford but presently lack access to such group coverage.

The bill would amend the Internal Revenue Code to accomplish basically *two things. First,* it would allow persons paying 100% of the premium for health insurance coverage providing a defined level of adequate benefits to deduct the full cost of their premiums separately from their gross income. *Second,* it would require employers to purchase group health insurance from an entity participating in the state risk pool or, if self-insured, to participate in the pool, if such a pool is available, in order to deduct the cost of their coverage as a business expense.

101st Congress
1st Session

DRAFT

BILL NO. ———

IN THE (SENATE) (HOUSE) OF THE UNITED STATES

DATE ——————

—————— OF —————— INTRODUCED THE FOLLOWING BILL;

WHICH WAS READ TWICE AND REFERRED

TO THE —————————— COMMITTEE

A BILL

To amend the Internal Revenue Code of 1954 to provide a deduction for certain costs incurred by individuals for health benefit plans and to provide incentives for the establishment of statewide insurance pools that provide health insurance to medically high risk individuals and to others who lack access to standard group rate coverage.

Be it enacted by the Senate and House of Representatives of the United States of America fin Congress assembled.

SECTION 1. DEDUCTION FOR PAYMENTS TO QUALIFIED HEALTH PLANS

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1954 (relating to medical, dental, etc., expenses) is amended—

(1) by striking out subsection (a) and inserting in lieu thereof the following new subsection:

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise

"(1) the amount by which the amount of expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for medical care of the taxpayer, the taxpayer's spouse or a dependent (as defined in section 152) exceeds 5 percent of adjusted gross income, and

"(2) the amount paid by an eligible individual to a qualified health benefit plan for individual or family coverage with respect to any time during any month of such taxable year during which the plan coverage is in force.";

(2) by redesignating subsections (c), (d), and (e) as subsections (d), (e), and (f), respectively;

(3) by inserting after subsection (b) the following new subsection:

"(c) LIMITATION WITH RESPECT TO PAYMENTS.—

"(1) COVERAGE FOR ONLY PART OF MONTH.—If an eligible individual is covered under a qualified health benefit plan for only a portion of a month, the amount allowable under subsection (a)(2) as a deduction with respect to such month shall be an amount which bears the same ratio to the applicable dollar amount under paragraph (1) for such month as such portion bears to the entire month.

"(2) MONTH.—For purposes of this subsection, the term 'month' means a calendar month.";

(4) by adding at the end of subsection (d) the following new paragraphs:

"(9) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual who, with respect to any month,—

"(A) has paid 100% of the premium for purchase of health benefit plan coverage under a health benefit plan (arranged for individually or by the individual's employer) made available by a qualified pooling association in such individual's state, or

"(B) who has paid 100, of the premium for purchase from insurance carriers of health benefit plan coverage offering adequate benefits comparable to a qualified pooling association's plan arranged for by an individual or by the individual's employer.

"(10) QUALIFIED HEALTH BENEFIT PLAN.—A qualified health benefit plan is a plan, provided directly or through insurance or otherwise, which—

"(A) provides coverage of adequate benefits as defined in sec. 213(d)(11);

"(B) provides some degree of beneficiary cost-sharing for covered expenses up to a specified per-person limit beyond which no further beneficiary cost-sharing for covered expenses shall be required. Such cost-sharing limit shall be the same for all subscribers and should be set at 10 percent of the national median family income rounded to the nearest $100—and should be adjusted for months in each calendar year after 1987 by the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on June 30 of the preceding calendar year. The Secretary of the Treasury shall publish the adjusted amounts prior to the beginning of the calendar year to which they will apply;

"(C) provides that there shall be no maximum limit—either lifetime or per episode—on the amount paid by the plan for covered expenses;

"(D) provides that, in paying for physicians' services, the amount allowed toward meeting the beneficiary's cost-sharing limit shall be the difference between the plan payment and the 90th percentile of physicians' customary or median charges in the local area (the amount which would cover the customary or median charge for a service at least 90 percent of the time it is performed).

Once such cost-sharing limit is reached, the plan shall pay the 90th percentile of customary charges in full. The plan shall continue to pay for hospital expenses on a service basis, with contractually specified beneficiary cost-sharing being applied toward the cost-sharing limit.

"(11) ADEQUATE BENEFITS—Adequate benefits include the following:

"(A) Coverage of diagnostic, therapeutic, or preventive medical services provided by or under direction of licensed physicians in the office, hospital or other setting, including—

"(i) Diagnosis and medical or surgical treatment of illness or injury,

"(ii) Psychiatric care,

"(iii) Diagnostic x-ray and laboratory services,

"(iv) Radiation therapy,

"(v) Consultation,

"(vi) Pre- and post-natal care of mother and infant, including delivery,

"(vii) Periodic medical examinations: 6 visits per dependent per year for the first year of life, biannually for ages 2–21, every 5 years for ages 22–40, every 2 years for ages 41–65, and

"(viii) Immunizations which are cost-effective for the beneficiary group covered;

"(B) Coverage of emergency and outpatient services for physical and mental illness, including—

"(i) Outpatient diagnostic services (x-rays, lab tests, etc.),

"(ii) Use of operating, cystoscopic, cast rooms and supplies,

"(iii) Use of emergency room and supplies for emergencies,

"(iv) Ambulance services, and

"(v) Treatment of alcoholism;

"(C) Coverage of inpatient hospital care for physical and mental illness, including—

"(i) Bed, board and nursing services,

"(ii) Drugs, oxygen, blood, biologicals, supplies, appliances and equipment used in the facility,

"(iii) Operating, delivery, recovery room charges; intensive coronary, special care, rehabilitation unit charges,

"(iv) diagnostic services (x-rays, laboratory tests, EKGs, etc.),

"(v) Care for pregnancy and complications, and

"(vi) Physical, Occupation, speech therapy;

"(D) Inpatient skilled nursing facility care for physical and mental illness, including—

"(i) Bed, board and skilled nursing,

"(ii) Physical, Occupation, speech therapy, and

"(iii) Drugs, biologicals, supplies or equipment used in the facility;

"(E) Home health services by a certified home health agency as ordered by a physician, including—

"(i) Nursing care,

"(ii) Physical, Occupational, speech therapy,

"(iii) Medical supplies and appliances (other than drugs and biologicals),

"(iv) Rental of durable medical equipment, and

"(v) Oxygen, blood, biologicals.

"(12) QUALIFIED POOLING ASSOCIATION.—The term 'qualified pooling association' means any organization which—

"(A) is established pursuant to state law;

"(B) permits any of the following doing business in the state to tie participating members:

"(i) insurers writing expense incurred health insurance,

"(ii) hospital and medical service plan corporations,

"(iii) health maintenance organizations and other health financing entities, and

"(iv) employers with self-funded, self-insured or non-insured employee health benefit plans;

"(C) makes available (without regard to health conditions) to all uninsured individuals (as defined in paragraph (13)) residing in the state levels of health insurance sufficient to provide adequate benefits as defined in paragraph (11).

"(D) charges a pool premium rate of not less than 110% nor more than 125% of the average premium rates for comparable group coverage in the state.

"(E) assesses losses of the pool equitably among all participating members.

"(13) UNINSURED INDIVIDUALS.—FOR PURPOSES OF THIS SECTION, AN UNINSURED INDIVIDUAL IS ANY INDIVIDUAL WHO—

"(A) is not eligible for coverage under an employment-based health plan (provided by insurance or otherwise) which provides adequate benefits as defined in paragraph (11), and

"(B) is not eligible for the Medicare program under title XVIII of the Social Security Act or for medical assistance under a State Medicaid plan approved under title XIX, of such Act.

(5) By adding at the end thereof the following new subsection:

"(g) RULE FOR NON-ITEMIZATION OF DEDUCTIONS.—In the case of a taxpayer who does not itemize deductions for the taxable year, the amount allowable under subsection (a) (2) for the taxable year shall be taken into account as a direct qualified health benefit plan deduction under section 63.".

(b) DEFINITION OF TAXABLE INCOME.—

(1) IN GENERAL.—Paragraph (1) of section 63(b) of such Code (relating to individuals) is amended—

(A) by striking out "and" at the end of subparagraph (B), and

(B) by inserting after subparagraph (C) the following new subparagraph:

"(C) the direct qualified health benefit plan deduction, and."

(2) DIRECT QUALIFIED HEALTH BENEFIT PLAN DEDUCTION DEFINED.—Section 63 of such Code (defining taxable income) is amended by adding at the end thereof the following new subsection:

"(j) DIRECT QUALIFIED HEALTH BENEFIT PLAN DEDUCTION.—For purposes of this section, the term 'direct qualified health benefit plan deduction' means the amount allowable under section 213(a) (2) which is taken as a direct qualified health benefit plan deduction for the taxable year under section 213(g).".

(c) CONFORMING AMENDMENTS.—

(1) Subsection (f) of section 63 of such Code (relating to itemized deductions) is amended—

(A) by striking out "and" at the end of paragraph (2),

(B) by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", and," and

(C) by adding at the end thereof the following new paragraph:

"(4) the direct qualified health benefit plan deduction.".

(2) Subparagraph (A) of section 3(a)(4) of such Code (relating to imposition of tax table tax) is amended to read as follows:

"(A) reduced by the sum of—

"(i) the excess itemized deductions,

"(ii) the direct charitable deduction, and

"(iii) the direct qualified health benefit plan deduction, and".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar months beginning after December 31, 1986, in taxable years ending after such date.

SEC. 2. DEDUCTION DISALLOWED FOR EMPLOYER CONTRIBUTIONS TO GROUP HEALTH PLANS NOT PARTICIPATING IN QUALIFIED POOLING ASSOCIATIONS.

(a) IN GENERAL.—Paragraph (1) of section 162(i) of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended to read as follows:

"(1) GENERAL RULE.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if—

"(A) the plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner,

"(B) the employer (1) purchases group health insurance coverage from an insurer writing expense incurred health insurance, a hospital or medical service plan corporation, or a health maintenance organizations, which is not participating in a qualified pooling association in any state in which the employer allocates group health plan expenses (provided that such a pool has been established and is in operation in such state), or (2) otherwise provides a health benefit plan to its employees and is not itself a member of a qualified pooling association in any state in which the employer allocates group health plan expenses."

(b) EFFECTIVE DATE. The amendments made by this section shall be effective with respect to taxable years beginning after December 31, 1989.

ERISA AMENDMENT FOR STATE REGULATION OF SELF-INSUREDS

This bill would amend the Employee Retirement Income Security Act (ERISA) to require states to regulate employers' self-insured plans in the same manner other health insurance plans are regulated. Under the present ERISA law, self-insured plans cannot be regulated by a state because ERISA preempts all state laws relating to employee benefit plans other than insurance, banking, and security regulatory laws.

101st Congress *DRAFT*
1st Session

BILL NO. ———

IN THE (SENATE) (HOUSE) OF THE UNITED STATES

DATE ————————

—————— OF —————— INTRODUCED THE FOLLOWING BILL;

WHICH WAS READ TWICE AND REFERRED

TO THE ———————————— COMMITTEE

A BILL

To amend the Employee Retirement Income Security Act of 1974 to eliminate the exemption in such Act of state laws with respect to employee welfare benefit plans which provide health care benefits.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Section 514 of the Employee Retirement Income Security Act of 1974 (21 U.S.C. 1144) is amended by deleting the period at the end of subparagraph (2)(B) and inserting in lieu thereof the following:

> ", except that in the case of an employee welfare benefit plan established for the purpose of providing medical, surgical, or hospital care or benefits, or any trust established under such a plan, any law of any State which regulates health insurance may apply to such plan."

STATEMENT OF THE AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries is a professional association representing actuaries in all areas of actuarial practice. Members of the Academy's Committee on Health who prepared this statement are employed both as consultants and by insurance companies. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers. The Academy and its committees do not advocate public policy positions that are not actuarial in nature. We view our role in the government relations arena as providing information and actuarial analysis to public policy decision makers, so that policy decisions can be made on the basis of informed Judgment.

The Academy regards the lack of health insurance coverage for approximately 31 million Americans (according to a recent Census Bureau estimate) as a very grave social problem. We have revised the proposed Basic Health Benefits for All Americans Act of 1999, S. 768, that would require most employers to provide health insurance to their employees and their dependents up to minimum standards, and assure provision of health benefits to under-poverty, near-poverty, and other individuals. We have also reviewed the HIAA's four-point plan to meet the needs of the various subpopulations within the 31 million uninsured. In addition, we have reviewed some state programs.

As a professional association, the Academy neither supports nor opposes legislation mandating employer-provided health insurance or providing access to health care for uninsurables and those who cannot afford health insurance coverage. However, before passing a national health insurance program, we urge you to once again review the underlying causes of lack of insurance to see whether these causes may be rectified without violating the risk evaluation principles which insurers must use to keep their prices affordable.

This statement will not cover Senator Kennedy's proposal (S. 768). Instead, we include as Exhibit I our statement to the Senate Labor Committee dated July 6, 1989. This statement discusses some potential problems in pricing, antiselection, and richness of benefits under this bill.

The first step in reducing the number of uninsured is to require all full-time employees to participate in currently offered employer health plans as a condition of employment. Thus, flexible benefit programs should require core health coverage of every employee (and for any dependents lacking other health coverage). Where employee contributions are required, there might be some legal problems in requiring the employee to contribute, absent specific legislation to that effect. Part-time and low-income employees may have a problem affording the employee contributions. A reduced level of required benefits might be the answer here, since this is preferable to no coverage. Basic rather than comprehensive coverage should be considered for these employees. For the low-income employee or non-employed individual who encounters a medical catastrophe, Medicaid should be made available after the appropriate spenddown of assets.

Carriers might be required to extend the eligible age to which dependents can remain covered under the family coverage of their parents. This would allow for the young people to have coverage while out of school and looking for employment, and those working part time. This extension, however, should be limited to age 25.

Second, insurers should be allowed to use their current rating and underwriting practices for small groups and individuals. Those rejected for, or priced out of, coverage under these practices could be assigned to a high risk pool (a state or insurance industry high-risk pool). This would reduce the potential antiselection in a comprehensive mandated program such as S. 768 there community rates are required. Also, to further enhance affordability, state mandated benefits should not be applied to small group, individual coverages, and high-risk pool coverage. The question of who is to subsidize the costs of the uninsured and by how much, is a difficult question, since potential funding sources (e.g., taxpayers. employers, insurers) for such subsidies are limited, and are perhaps already taxed too heavily. Sin taxes are also a possibility, but may have already reached their saturation point as people develop better lifestyles. For those uninsureds denied coverage for reasons of poor health, or offered insurance either with non-affordable premiums, or with restrictive pre-existing condition exclusions, state high-risk pools allow some access to health care. Fifteen states currently have such pools. However, because of their expense, these risk pools do not assure access to health insurance. At least one state has a premium subsidy program which is a part of the state high-risk pool. For those priced out of the state high-risk pool access, Medicaid is available after the appropriate spend-down requirements. The premium charged high-risk pool members, although high, is capped (usually at about 150% of the standard premium), and has been found to be insufficient to pay all claims and administrative expenses. To get a reading on this deficiency, the existing state high-risk pool experience was examined, with the result that the average risk of the existing high-risk pools was about 2.5 times the average risk of the insured population. Exhibit II shows further details of this analysis.

Finally, we should first evaluate the results of current state experiments[1] which are primarily focused in providing coverage to the employed uninsured. This should give us a better understanding of the problems involved in this complex issue, and which solutions might be workable, before we propose a national program for the uninsured.

CONCLUSION

We appreciate the opportunity to comment on these issues. Our committee would be pleased to answer questions you may have about this statement or provide further assistance to your committee. Because of our experience in health care financing and insurance, we believe that we can assist you in identifying and weighing the merits of proposals to provide health benefits to the uninsured. We hope the comments presented in this statement will be useful in helping Congress to deal appropriately with this complex problem.

EDWARD J. WOJCIK, *Chairperson,*
Committee on Health, American
Academy of Actuaries.

Attachments.

EXHIBIT I.—SENATE LABOR COMMITTEE HEARING ON KENNEDY MANDATED EMPLOYER-PROVIDED HEALTH BENEFITS PROPOSAL, THE COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES, JULY 6, 1989

The American Academy of Actuaries is a professional association representing actuaries in all areas of actuarial practice. Members of the Academy's Committee on Health who prepared this statement are employed both as consultants and by insurance companies. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers The Academy and its committees do not advocate public policy positions that are not actuarial in nature. He view our role in the government relations arena as providing information and actuarial analysis to public policy decision makers, so that policy decisions can be made on the basis of informed judgment.

The Academy regards the lack of health insurance coverage for approximately 31 million Americans (according to a recent Census Bureau estimate) as a very grave social problem. We have reviewed the proposed Basic Health Benefits for All Americans Act of 1989, S. 768, that could require most employers to provide health insurance to their employees and their dependents up to minimum standards. As a professional association, the Academy neither supports nor opposes legislation mandating employer-provided health insurance. We commend Senator Kennedy for recognizing that to cover all uninsureds both the public and private sector programs must be expanded with a subsidy provided to small businesses to ease their financial burden. We would like to indicate some potential problems with the regional community pricing mechanisms and richness of benefits proposed in Title III of S. 768. We also would like to make known why costs for small group employer coverage are much higher than for large group employer coverage.

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[1] Experimental programs of which we are aware are being conducted in Massachusetts, Minnesota, Washington, Oregon, Wisconsin, Rochester, N.Y., and Michigan.

COMMUNITY RATING

The community rating concept pools all entrants of a particular class together to pay the same rate for the same level of benefits. In the case of this bill the particular class is the small group class (under twenty-five employees). The principle works and is good as long as there is a good cross section of risk in such a pool, i.e., a good cross section of high- and low-user groups. Requiring insurance carriers to provide small group health coverage on a community-rated basis can cause problems in several ways. The underlying problem with community rating is that it does not reflect variation in health care costs due to factors such as age, industry, and geography. In general, good risks avoid or drop out of a community-rated pool, leaving behind the poorer risks for whom community rates are a good buy. This situation could require either further rate increases or a considerable drain on a company's surplus to compensate for the inadequacy of rates for the remaining risks. Even increasing rates may be ineffective, for doing so may stimulate a further round of groups dropping out. This typically leaves an even poorer cross section of risks in the community pool, requiring even higher rates. This process, referred to as an "adverse selection spiral," is very familiar to life and health insurers. It could make the costs of some competing regional carriers spiral out of control, while the costs of other carriers (who have attracted more favorable health risks) remain affordable. This process has been a prominent feature of the operation of the Federal Employees Health Benefits Program.

The advantage of community rating to the regional carrier would be the relative ease in administration, but the disadvantage to the carrier is that groups with good experience would tend to cancel and re-enroll with another regional carrier if the rates were loner. The advantage to the group is that there are no drastic rate fluctuations because the low-user groups support high-user groups. However, while high-user groups are satisfied, the low-user groups would tend to cancel.

S. 768 allows actuarially equivalent plans, at least with respect to variation in copayments, deductibles, out-of-pocket limits and employee contributions. This feature would appear to encourage competition among regional insurers. This should facilitate groups moving from insurer to insurer. The down side of this is that community-based rates may prove inadequate and an insurer may face solvency problems.

Existing small groups will be allowed to keep their coverage with their current carrier. These small groups would be below average cost since they would not include uninsurable groups, and at present are satisfied with the cost of insurance for the benefits provided. However, those groups without coverage, and existing groups that cancel their coverage with the current carrier, must do business with one of the regional carriers. These groups will have risk characteristics that are much worse than the aforementioned groups which have coverage through their present carrier.

Second, there could be a large amount of anti-selection between carriers because of cost differentials by area (rural versus metropolitan) as well as by state. Large cost differentials among groups with differing profiles of age, gender, and (to a lesser extent) family size could also contribute to such selection. Finally, there could be an inordinate amount of selection within a carrier between the high- and low-option benefits that must be offered. This belief is based on the fact that the characteristics of the small group uninsured population are largely either (1) unaffordability or (2) uninsurability. Therefore, those groups that cannot afford insurance would choose the lox-option, lowest-priced coverage, while the groups that can afford premiums would, in most cases, choose the high-option coverage. Because it is to their financial advantage, uninsurable groups would also tend to choose the high-option coverage.

While a better than average cross section might be attainable on the respective low options, this would not be the case for the high-option coverages, making the price of the high-option coverage too costly. This would cause some of the better risks of the high-user groups to transfer to another carrier or even to a low option, causing the costs for the high option to spiral, and perhaps eventually become unaffordable.

Charging each group a premium that represents its risk level may not be a viable solution since premiums for high-risk industries in high-cost geographic areas can be many times the premiums for low-risk industries in lover-cost geographic areas. Since this system may make coverage prohibitively expensive for some groups, the objective of making insurance accessible to all groups may not be achieved.

One way of mitigating this problem would be to allow some form of subsidy for high-risk groups which would keep premiums from being higher than a certain percentage over standard rates. Alternatively, companies could be allowed to rate groups by class (similar to federally qualified HMO's) to reflect their risk and geographic cost level, also limiting rates to certain ranges, thereby avoiding substantial cost variations. High risk groups could be shifted to a high risk pool. In addition, allowing phase-in of the preexisting condition prohibition would help mitigate the antiselection.

RICHNESS OF BENEFITS

The package proposed by the Kennedy/Waxman bill is comprehensive, including the outpatient psychiatric addition. For small groups that supposedly could not afford such coverage, the benefits are rich with a handsome price tag attached. This bill, in fact, counteracts cost containment efforts in other areas and would tend to increase health benefits as a proportion of the gross national product as utilization will certainly increase for this segment of the population.

The maximum limitation for deductible of $250 (single contract) and 2-coinsurance up to a limit of $3,000 out-of-pocket expenses (uncertain whether for single or family) as a low-option benefit program limitation, with lower deductibles, coinsurance, and out-of-pocket expense limitations for the high-option benefits, would not be conducive to reducing the escalation of health care costs.

The introduction to S. 768 in the Congressional Record suggests that managed care could reduce claim costs by 15%. While such reductions have been achieved in managed care programs on a local basis, managed care savings are typically much less when averaged over wider geographic areas. A recent national survey indicates that initial savings due to managed care amounted to only 4% to 5% of claim costs in the first program year, with savings in following years dropping around 1% (i.e., to 3% to 4% of claim costs). These savings do not reflect the increased costs needed to administer the managed care program, which amount to about 1.5%. Thus, based on this survey, net savings from managed care over broad geographical areas would typically amount to around 2.5% to 3.5% of claim costs in the first year of the program, falling to 1.5% to 2.5% of claim costs in following years.

We suggest that regional insurers be permitted to offer only low option benefits (i.e., the minimum benefits proposed in Title III) for a start in order to hold down the costs for both employer and employee.

COORDINATION OF S. 768 WITH STATE INSURANCE REGULATION

S. 768 extends the ERISA preemption to any state insurance laws or regulations "relating to contracts or policies of insurance issued to or under a health benefit plan under Title III of the Basic Health Benefits for All Americans Act." [Title I, section 202(a)(2)(C)] This provision clears the legal and regulatory ground for Title III to require health benefit plans to meet certain coverage, benefit design, and other requirements. However, the scope of the ERISA preemption raises questions about the role intended by S. 768 for state regulation of insurer financial solvency, and other issues. For example:

1. Will state insurance regulators still have any responsibility for rate regulation in the large (over-25-employee) group health insurance marketplace?
2. How will S. 768 affect the operation of state guarantee funds protecting policyholders in case of insurer insolvency
3. Are state premium taxes on health insurance premiums to be eliminated?
4. Are even premium taxes earmarked for solvency guarantee funds to be eliminated.
5. Would S. 768 prohibit allocating state income, or other non-premium, taxes to the health benefit plan segment of the business?

As the above questions indicate, the ERISA preemption in Title I may have been framed more broadly than the drafters of S. 768 intended. Some clarification (and, if appropriate, redrafting of the preemption language) would be helpful.

HIGHER COST OF HEALTH INSURANCE FOR SMALL GROUPS

Factors contributing to the high cost of health insurance for small employers, as compared to the cost for large employers, include the following:

1. Smaller base of employees and premiums over which to spread various fixed expenses.
2. Higher claim level due to the unavailability of workers compensation for small groups in some states.

3. Certain adverse selection effects that remain even with pooling or community rating because of the greater variability of small group risk cross section as compared to large groups.

4. Larger group avoidance of state mandated benefits, premium taxes, and risk charges by self funding (through claiming ERISA preemption of state insurance laws).

5. The high turnover of small-group employers who readily switch carriers because they are price sensitive. This entails a higher risk charge and faster amortization of initial expenses.

6. Various benefit management and accounting functions are provided in-house on a large employer's health insurance program. Since small employers cannot afford the personnel to perform these functions, they are performed by the insurer, and the additional costs are reflected in the small group's rates.

The above factors can readily add up to a substantial difference. These explanations are given not only to help better understand the difference between small and large group costs, but also to indicate that a regional insurer will most probably be unable to price the mandated products for small groups as cheaply as for large groups.

ESTIMATED COSTS UNDER TITLE IV OF S. 768

With respect to Title IV of S. 768—"Assuring Provision of Health Benefits to Under-Poverty, Near-Poverty, and Other Individuals," we agree that there is a great need for access to care. A rough estimate of initial additional taxpayer costs for the below-poverty-level persons coverage in 1991 is in the range of $9 to $10 billion annually for the 6 million persons in this category. However, note that the very presence of insurance could cause these costs to escalate rapidly especially in view of Title IV's lack of utilization controls and insured cost sharing. The Medicare program serves as an example of the kind of cost escalation that is possible over the years in a generous insurance program without (until recently) significant cost controls.

CONCLUSION

We appreciate the opportunity to comment on these issues. Our committee would be pleased to answer questions you may have about this statement or provide further assistance to your committee. Because of our experience in health care financing and insurance, we believe that we can assist you in identifying and weighing the merits of proposals to provide health benefits to the uninsured. We hope the comments presented in this statement will be useful in helping Congress to deal appropriately with this complex problem.

Edward J. Wojcik, *Chairperson,*
Committee on Health, American
Academy of Actuaries.

EXHIBIT II.—ANALYSIS OF EXISTING STATE HIGH RISK POOL EXPERIENCE [1]

(a) Persons insured at end of 1987	23,010
(b) Earned Premium	$28,666,026
(c) Incurred Claims	$51.013,890
(d) Administrative Expenses	$2,637,462
(e) Gain/Loss [b − c − d]	($24,985,326)
(f) Loss Ratio [c ÷ b]	178%
(g) Earned Premium Based on Average Risk [2]	$20,971,202
(h) Associated Risk Level of State High Risk Pool Enrollees Compared to Average Risk [c ÷ g]	243%
(i) Average Annual Premium Per Person in State High Risk Pool [b ÷ a]	$1,245.81
(j) Expense as % of Premium [d ÷ b]	9.2%
(k) Expense Per Person [d ÷ a]	$114.62
(l) Claim Dollars Per Person [c ÷ a]	$2,217.00

[1] Connecticut (joint only), Florida, Indiana, Minnesota, Nebraska, North Dakota, and Wisconsin.

[2] Earned premium reduced for the loading (estimate based on premium caps).

NOTE: Items i, k, and l use a as a denominator persons insured at and of 1987 rather than average persons insured during the year).

STATEMENT OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

INTRODUCTION

The American Public Welfare Association (APWA) has given the issue of access to health care a great deal of consideration over the past several years. We came to realize that as the cost of health care rises, access to care is eroded by a variety of convergent factors. It also became clear to state human service administrators that Medicaid, as currently constituted, cannot address all the problems which surround the issue of access to health care.

APWA is a 59-year-old non-profit, bipartisan organization representing the 50 state human service departments, 800 local public welfare agencies and 6,000 individuals nationwide. APWA established a Task Force in 1987 to study access to health care. The Task Force members represented a cross-section of states and professional expertise. The recommendations developed by the task force were published on the fall of 1988, in the *Access* report. The report calls for reform of the health care financing system through a public/private approach to universal coverage.

THE DILEMMA

We are all well aware of the statistics associated with the uninsured. For the welfare systems we represent, these statistics hit home on a daily basis. Although Medicaid is designed as a health care financing program for the poor, it cannot meet the needs of all the poor and near poor. Despite incremental expansions for selected populations, the program cannot begin to help all the working poor and uninsured.

Because Medicaid cannot address the needs of all the uninsured, that responsibility is shifted onto the larger health care delivery system. Most of our large public hospitals and other health care institutions are struggling to survive under the demands of care of the medically indigent. Many hospitals find they cannot survive unless they take steps to limit access to the services used most frequently by the uninsured and underinsured.

Human service administrators understand the links between poverty, welfare, and access to health care. Today poor families seeking to leave the welfare rolls for employment face a disincentive in the eventual loss of Medicaid benefits. While the Medicaid transition provisions of the Family Support Act begin to bridge that gap in coverage for this population by providing 12 months of medical assistance for former welfare families, there is still much that remains to be done.

Because many former families leave public programs for low wage employment that frequently does not provide workplace insurance coverage, the Family Support Act's 12 month extension of medical assistance is only a partial solution. Such families cannot secure employer-sponsored insurance as they enter the workforce, nor can they afford to purchase coverage from the low wages they earn. Many former recipients are forced to leave their jobs and return to welfare in order to meet the health care needs of their children.

In addition, there is the much larger population of uninsured, unrelated to AFDC, who are employed but do not have access to workplace coverage and are without the adequate financial means to provide for such coverage individually. The number of uninsured and underinsured who have ties to the workforce grows substantially each year.

Though it is commonly believed that most of those without insurance are unemployed, that is not the case. In actual numbers, and as a percentage of the workforce, the number of workers without health insurance is increasing. In 1985 almost 75 percent of the uninsured were either employed, or dependents of wage earners. From 1982 to 1985 the number of workers without insurance rose from 13.9 million to 17 million, an increase of 22.5 percent.

As more people fall through the cracks in the current financing and delivery system, it becomes clearer than ever before that action must be taken to address the problem. More than incremental expansions in Medicaid eligibility, the country must begin to take a broader view of the problem of access.

APWA RECOMMENDATIONS

The APWA Task Force was established to propose alternatives to that families do not face the stark choice between take a low-wage job without insurance and remaining on welfare in order to secure Medicaid benefits for their children. The task force believed that any policy proposal must also assure that any member of the workforce is not reduced to economic dependence by his or her lack of health insurance.

The task force recommendations are built upon two basic principles: (1) that individuals have a responsibility to obtain health care coverage for themselves and their children when it is available and affordable; and (2) that society has an obligation to ensure access to health for all citizens.

In addition to the two overreaching principles, the task force established several basic guidelines by which to evaluate alternative recommendations and policies. These guidelines include:

Equity—families in similar economic circumstances should be treated similarly

Benefit Coverage—everyone should be covered by at least a minimum package including primary and preventive services

Work Incentives—coverage should act as incentive to participate in the workforce

Economic Impact—any policy should minimize the amount of adverse economic impact experienced by business

Effective Administration—any policy should be conducive to effective and efficient operation

Economic Efficiency—any policy should lend itself to cost control

The Task Force concluded that the most expeditious way to deal with the problem of the uninsured is to build upon the existing systems of coverage—workplace plans and Medicaid problem. In this manner, all those who currently lack affordable insurance can be covered. Last November we published our recommendations in the report entitled *Access*, which members of the Senate Finance Committee received. The APWA proposal calls for mandated employer sponsored health insurance and an expanded public program to provide coverage for all those not covered through the workplace. The recommendations build on existing, well-established mechanisms by which the clear majority of the people gain access to health care. APWA believes that these two components can provide for universal access for all the un- and under-insured.

EMPLOYER-SPONSORED COVERAGE

APWA believes that the private sector has a responsibility to provide health care coverage for its workers. This is a cost that government and the public health care delivery and financing systems can no longer afford to shoulder without the full and direct assistance of the private sector. Consumer cross-subsidy of the costs of care for the working uninsured is fast becoming an untenable proposition within an increasingly competitive health care system that is, of necessity, ever more focused on cost-containment. In addition, given the large Federal deficit and growing state fiscal problems, government at all levels cannot afford to provide the necessary coverage for all the working uninsured, either directly or indirectly.

APWA recommends employer-sponsored health insurance for all employed individuals and their families, with a basic package to include hospital and physician services; prenatal, well-baby and well-child care and diagnostic and screening tests. For small businesses, coverage would be provided through regional insurance pools offering premium rates dual to those available to large firms.

Further, state human service administrators believe that government should subsidize the insurance costs of small businesses that may not be able to sustain such costs without assistance through economic development funds. APWA also believes it is possible to structure the insurance pools so that workers with chronic conditions (the uninsurable) could be covered.

The APWA proposal calls for mandated workplace coverage for all workers, not just those who are fortunate enough to work more than part-time. We are concerned that employers may reduce the number of employee hours worked in order to avoid the mandate. We also believe it is possible to provide coverage to temporary and intermittent workers through the regional insurance pools. It seems that limitations on any mandate will only result in continued indirect, but significant, government subsidy of private sector costs of care through the public programs and indigent care costs. APWA believes it is ultimately more efficient and effective for government to subsidize the costs to employers of such coverage. To do otherwise would mean government payment of full insurance costs for the working uninsured, or indirect public payment of expensive acute and emergency care at hospitals and other non-primary care provider sites.

Under the APWA proposal, individuals would be required to contribute to the costs of cover. Full-time employees would be required to pay 20 percent of the premium costs. Government subsidy would be available for low-income workers, with full subsidy up to 75 percent of poverty and sliding scale payments between 75 percent and 200 percent of poverty. For part-time employees, the employer would pay a premium based on average number of hours worked—so that an employer is not carrying the burden of full-time coverage for part-time work. The employee would be required to pay the premium balance. Again, government assistance would be available for low-income workers.

EXPANDED PUBLIC PROGRAM

The second component of the APWA proposal addresses the needs of the nonworking uninsured. We recommend a restructured Medicaid program to cover all nonworking individuals and families. The benefits in the public program would be equivalent to the basic employer-sponsored package. The APWA proposal assumes that individuals should contribute to the cost of coverage in relation to their income, so that the program can be made available to all the nonworking uninsured regardless of their income. Poor individuals and families living below 75 percent of poverty would enroll at no cost, while families living between 75 percent and 200 percent of poverty would pay on an income related sliding scale. All other nonworking eligibles would pay full premium costs.

The individual contribution to coverage will overcome one of the basic problems with the current Medicaid program-that it is available to only the poorest of the poor and that there is no buy-in mechanism for people of means who nonetheless do not have access to insurance either because they are considered "uninsurable" by underwriters or because they cannot afford the very high cost of an individual, nongroup, policy.

The Task Force concluded early in its discussions that to meet different needs, different policies must be pursued, and these two proposals meet the varied needs. They would permit and promote effective administration because they are based on existing programs and services. The recommendations also take into account the current broad consensus that employers have a responsibility to provide coverage to workers-indeed if all employers provided insurance, the number of uninsured Americans would decline substantially.

CONCLUSION

APWA has historically supported breaking the link between cash welfare programs and Medicaid eligibility. State human service administrators have been pleased to see the progress made in expanding program flexibility to cover pregnant women and infants, regardless of their eligibility for other public assistance programs.

Ultimately, however, the country needs a broader view of health care financing and service delivery. With the growing numbers of uninsured workers it is increasingly clear that incremental expansion of Medicaid coverage and eligibility will not solve the access problems for all the uninsured. The problem of financial access to health care is a problem not only of the poor, and cannot be treated as such. Government alone cannot, however, afford to provide publicly sponsored coverage to all the working uninsured. Even if government funds were available to provide coverage for all the working uninsured, it would not make sound public policy. Such broad public coverage might undermine existing employer sponsored coverage and undercut the private insurance market.

Together, the public and private sectors can begin to address the problem. Employer mandated insurance, with the private sector providing for its fair share, and a broader role for Medicaid, are the only viable solutions to the crisis within the parameters of the existing systems. APWA believes we must begin to look beyond segmented, incremental expansions of the current public programs and move toward broad reform of the health care financing system. Building a system that can provide universal access to health care will require the participation of both the government and the private sector.

STATEMENT OF THE MANUFACTURERS' ALLIANCE FOR PRODUCTIVITY AND INNOVATION

Chairman Riegle and Members of the Subcommittee: We appreciate the opportunity to comment on proposals to provide universal access to health care. MAPI is a policy research organization whose 500 member companies are drawn from a broad cross-section of industry, including leading companies in heavy industry, automotive, electronics, precision instruments, telecommunications, computers, chemicals, oil and gas, aerospace, and similar high technology industries.

The Finance Subcommittee on Health for Families and the Uninsured has identified an extremely serious problem facing the U.S. health care system: the growing number of Americans who lack access to needed health services. However, as

MAPS's recent report, *Crisis in the U.S. Health Care System: How Should Government and Industry Respond?*, points out, any program for increasing access that does not include cost containment as a concurrent goal inevitably will fail. Health care expenditures continue to rise out- of-control and a country that continues to devote an increasing proportion of its national output to health care, such as the United States is doing, places its future in jeopardy. This proportion—now 11 percent of Gross National Product (GNP) and forecasted to be 15 percent by the year 2000—far exceeds our investment in education and in research and development. It also now exceeds investment in new plant and equipment, a major source of future economic growth.

There is also growing evidence that some expenditures on health care are unnecessary and that people are receiving treatments that may be unneeded, ineffective, or actually harmful. One rough measure of this excessive expenditure can be found in international comparisons: on a per capita basis, the United States spends more on health care than do other industrial nations, yet Americans do not appear to be healthier than their foreign counterparts.

While a significant proportion of the population is consuming increasingly expensive medical services, there is a growing segment of the population that lacks access to all but emergency services. This group typically have no access to employer-based group health insurance and yet they are ineligible for public assistance programs such as Medicaid, since those programs do not cover all the poor. Their relatively low income and the high cost of individual health insurance policies mean that they often have no way of obtaining health insurance on their own. Providing for these uninsureds should be a high public policy priority because a lack of insurance coverage usually translates into a lack of access to needed health services. This is particularly true given the high cost of health care. Few individuals can afford to pay the entire cost of even a moderately short hospital stay without drawing on their home equity or retirement savings. Those who lack these or similar assets could find themselves quickly impoverished to the point where they become dependent on public assistance.

THE SEARCH FOR SOLUTIONS

There is a real danger that in our efforts to increase insurance coverage, further health care cost escalation will occur. Containing the growth of health care expenditures must be an important component of any plan to increase access; otherwise, our ability to provide health services or other services eventually will be limited. This trend of devoting increasing amounts of resources to health care inevitably will crowd out expenditures for other important goods and services, including those investments in education, research and development, and plant and equipment that are the basis of our future standard of living.

It is our opinion that both problems need to be faced simultaneously if a solution is to be found for either problem. Just as cost containment through limits on access is not acceptable, so, too, increasing access without cost containment is unacceptable. If we do not change the way health care is produced, consumed, and paid for in this country, we face the prospect of a health care system that not only fails to provide for a significant portion of our population, but one that is second-best.

One proposal now receiving serious consideration is legislation which, among other things, would require all employers to provide health insurance to their full- and part-time employees. Proponents of this legislation, the "Basic Health Benefits for All Americans Act" (S. 768), sponsored by Senator Edward Kennedy (D-MA), see this approach as an equitable way to provide the working uninsured with access to health services. Although this mandated approach has several positive features, we believe that its enactment would further fuel the cost escalation problem and result in an even higher proportion of the nation's resources being spent on health care. It is not that we spend too little on health care, it is that our health dollars are badly allocated. Legislation, such as S. 768, is a crutch that would allow the system to limp along a little longer by reducing the immediacy of the problem. If this approach is taken, we end up postponing much-needed changes, allowing the problem to become even more serious.

PROBLEMS WITH MANDATING EMPLOYER-PROVIDED HEALTH INSURANCE

Senator Kennedy's bill is designed not only to extend insurance coverage to the uninsured, but also to attract support from the insurance industry, hospital administrators, and groups of physicians. The additions in the current version of this bill, such as the small business subsidy, seem to follow the principle of "give everyone something so no one will complain." The bill fails to explain how these additional health benefits will be financed.

The cost of providing for the various legislative proposals aside, the primary reason for rejecting the mandated benefits approach to improving access is that it does nothing to constrain the rising cost of medical services or to reverse the trend toward more and more of the nation's resources being consumed in health care. By expanding a system that has serious flaws, the "Basic Health Benefits for All Americans Act" would result in a significant escalation in health care costs, if enacted. This could have serious consequences for the competitiveness of U.S. industries, some of which are already at a comparative disadvantage because of out-of-control health care costs. For example, the Chrysler Corporation compiled statistics which show that their health care costs equaled $700 per vehicle as compared to $337 per vehicle for German cars and $246 per vehicle for Japanese cars.[1]

A lesson from Massachusetts.[2]—Although the two programs have differences, Massachusetts' Universal Health Care Law, adopted in 1988, and Senator Kennedy's "Basic Health Benefits for All Americans Act" have important similarities: both bills center on employers as a primary source for health insurance. The Massachusetts bill is more flexible than the Kennedy bill in that it offers employers the Hobson's choice of providing at least $1,680 worth of insurance premiums to each covered employee or to pay the difference between the employer contribution and the $1,680 to the state as a tax. Massachusetts' employers also will be required to pay a per-employee tax to cover the unemployed.

The Massachusetts bill also includes provisions to help curb the high cost of health care in the state. Part of this effort takes the form of a cap on the employer-provided contribution to the state's free care/bad debt (FC/BD) pool. This pool is financed by a surcharge that is added to all hospital admissions paid by private sources. When first established in 1985, the surcharge (or tax) equaled 9.8 percent. It rose by over one-third in just three years to 13.06 percent in 1988, yielding contributions to the pool totaling $325 million. Under the new law, the private sector share of the FC/BD pool is limited to the $325 million. The state agreed to pay the next $48 million required to finance these shortfalls and to split 50–50 any additional required funds with the private sector.

Unfortunately, Governor Dukakis' fiscal year 1990 budget does not include a request for the estimated $77 million needed over the three remaining years of the bill's requirements to cover the Commonwealth's share of the FC/BD pool. The Governor's budget proposal also neglects to request funding for the Commonwealth's share of the Medicare shortfall ($37.5 million), provided for in the bill. Finally, there are other health financing problems, including $250 million in unpaid Medicaid bills owed by the state.

Given the financial problems of his state, there is the possibility that Governor Dukakis will recommend that the cap on private payments to the FC/BD pool be lifted or eliminated. There is also a chance that private employers will be required to pick up the Medicare shortfall. And if the Commonwealth is made to pay its Medicaid bills, another tax on business may be chosen as the way to raise the $250 million needed.

Massachusetts is a relatively wealthy state with very low unemployment. Only 10 percent of its population currently lacks health insurance as compared to 18 percent for the country as a whole. Even though the Massachusetts mandated health insurance bill attempts to control costs, in practice these measures to constrain cost escalation have not been effective. Costs per employee are destined to rise to the point where the increased fixed cost of hiring under mandated benefits will adversely affect the number of people hired unless changes are made to the existing legislation.

The Massachusetts experience should serve as a warning: mandating that all employers provide health insurance is likely to exacerbate the crisis in the U.S. health care system. While well-intentioned, the Commonwealth's approach is likely to become a "shell game," controlling public expenditures by- shifting the ever-increasing costs to the private sector. The $1,680 figure set as the per-employee cost for the 1992 implementation of the Universal Health Care System could conceivably double by 1993 as hospital costs skyrocket to cover the government shortfall. Simply changing who pays does nothing to make health care affordable for everyone.

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[1] Ron Winslow, "National Health Plan Wins Unlikely Backer: Business," *The Wall Street Journal*, April 5, 1989, p. B1.

[2] Associated Industries of Massachusetts, "Legislative Bulletin," Volume 28: Special Supplement, June 1988, Parts 1 and 2.

There is no reason to expect that Senator Kennedy's "Basic Health Benefits for All Americans Act" would suffer a kinder fate. Guaranteeing providers with the opportunity to experience a significant increase in demand for health services with no mechanism to control costs will simply divert more of the nation's resources to health care.

Under this national reform of health care the cost of the "basic" health care plan would rise substantially as the currently uncompensated costs incurred by physicians and hospitals are included in the premium costs. In addition there is a high probability that the tax incidence of two of the components of S. 768, the small business subsidy and the Medicaid expansion, would also fall on employers as additional payroll taxes. Under this proposal, employees are likely to find that increasing amounts of their disposable income are being absorbed by rising health care costs.

ALTERNATIVES TO MANDATED BENEFITS

Before the problem of increasing access can be effectively addressed, the sharp increases in health care cost must be contained. In a world characterized by scarcity and competing uses for resources, our health care system cannot be allowed to continue to claim an increasing proportion of our total output. This is particularly true since there is growing evidence that a substantial portion of total health care expenditures is wasted. At the same time we discuss how to provide the uninsured with coverage, we must also find a way to afford the coverage that is currently being delivered. Otherwise, a solution to the uninsured problem could ultimately contribute to a decline in the ability of the U.S. economy to meet a wide range of economic and social needs. In its report, *Crisis in the U.S. Health Care System*, MAPI presents a strategy for controlling the rising cost of health care services. The report also recommends alternatives to the mandated health care proposals for improving access.

PROTECTING UNINSURED WORKERS

First, the tax law should be changed so that other forms of business organizations have incentives equal to those given to corporations to provide employer-sponsored health insurance. We strongly support this provision of the Kennedy bill.

Even with increased incentives, we realize that some businesses will not provide health insurance to their employees. The lack of access to affordable insurance is a real problem for those whose employer does not offer a group policy. It also is a problem for small businesses which would like to offer health insurance, but cannot afford the high cost of individual coverage which is essentially all that insurers offer to small groups. While the Kennedy bill attempts to solve this problem through the establishment of multi-state pools, individual states have tried other solutions. Some of these have chosen plans that rely more on the market to reduce the uninsured among the working population. While most of these programs were established too recently to be able to judge their effectiveness, they serve as examples of how insurance coverage can be provided for the working uninsured at reasonable prices, without large government expenditures. By using its market clout as a large purchaser of insurance for its Medicaid program, Arizona, for example, was able to negotiate an attractive rate for its plan participants, and Tennessee was able to arrive at a mutually advantageous arrangement with a hospital. Neither plan is mandatory, yet both appear to be successful in increasing insurance coverage. Most importantly, however, these types of programs increase access without the negative impact on job creation that mandated employer-provided health insurance plans would have, and they both include some provision for cost containment.[3]

Other programs designed to increase insurance coverage are also being tried by individual states. These include subsidies to employers who hire workers on public assistance, subsidies paid directly to qualified employees, and tax credits given to small firms that meet certain benefit requirements.[4] These types of programs require a higher degree of government involvement and government expenditure than do the pool-creating programs listed above. But even these types of programs are preferable to the mandated approach. However, so far this year, six states have followed Massachusetts' lead and mandated employer-provided health care.[5]

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[3] Office of Advocacy, U.S. Small Business Administration, "Expanding Health Coverage in Small Business: State and Local Initiatives," December 1988, pp. 3-5, 26-28.

[4] *Ibid.*, pp. 1-2.

[5] Intergovernmental Health Policy Project, The George Washington University, "State Health Notes," Linda Demkovich, ed., Number 91, March 1989, p. 1.

IMPROVING ACCESS FOR POOR AND LOW-INCOME

The Medicaid program currently exists to provide health services to low-income families, headed by individuals most of whom are not in the labor force. Because each state designs its own program within broad Federal guidelines, there are actually 52 individual and different Medicaid programs. Unlike Medicare, which insures virtually all of the elderly, Medicaid only covers a portion of the poor. "Federal and state limitations result in the denial of Medicaid protection to nearly 60 percent of impoverished Americans."[6] MAPI, therefore, supports the provisions of S. 768 that would expand the Medicaid program. This approach is consistent with the principle that if a lack of health insurance protection is the result of insufficient income, it is preferable to respond by an explicit government expenditure, rather than shift the cost to employers who provide health insurance to their employees.[7] In order to make the costs of these programs very explicit, it may be necessary to place all health care expenditures, including Medicaid and Medicare, in a specific health care budget. In this way, the total public funds to be spent on health care could be set in advance.

HEALTH CARE VOUCHERS

All of the suggestions described so far have offered a piecemeal approach. What actually may be needed is a major reform of the health care payment system. One approach that seems particularly promising is the proposal made by economist Alain Enthoven. He proposes a refundable tax credit equal to 60 percent of a family's "actuarial cost" of health insurance that would replace the existing system's employer exclusions and deductions. The employer's contribution to the employee's health insurance would be reported as taxable income and the tax credit would be allowed only as an offset to actual cost of the insurance premium. As Enthoven states, ". . . this would be a form of compulsory premium contribution through the tax system. "[8] A voucher system for the purchase of insurance would be established for the poor, with the dollar value of the voucher related inversely to family income.[9]

FINANCING IMPROVED ACCESS

It is not probable that, even if we were to achieve improved efficiency in the production and distribution of health care services, sufficient money would be generated to fund coverage for those currently without health insurance protection; therefore it is necessary to consider how revenue could be raised. One possibility is for some portion of the employer's contribution to the premium cost to be counted as taxable income to the employee. As mentioned earlier, $37.3 billion in "tax expenditures" is attributable to this provision in the tax code. It does not seem equitable for society at large to be contributing to "Cadillac" plans through tax expenditures, while some taxpayers lack any coverage, even though they pay a wage tax to finance the growing cost of health care for the elderly.

CONCLUSION

Just as many of our other industries have had to undergo significant transformations, there is no doubt that the U.S. health care system is also in need of major reform. This industry has been able to resist for too long the competitive pressures that would push it towards a more efficient use of its resources. However, real reform will require action by federal, state and local governments, private industry, and individual consumers. As both producers and consumers, the various levels of government have the responsibility to see that public dollars are spent effectively. Private industry has the responsibility to strengthen the ties between the economic decision-maker and the price and type of health service consumed. Individuals have the responsibility to become more involved in their health care and to work with the doctors and hospitals to decide among available treatment alternatives.

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[6] Sar A. Levitan and Elizabeth A. Conway, "To Our Good Health: Toward Affordable Health Care For The Nation's Families," Draft Paper, March 1 1989, Center for Social Policy Studies, The George Washington University, p. 24.

[7] Marvin Kosters, "Mandated Benefits—On the Agenda," *Regulation*, 1988, Number 3, pp. 21-27.

[8] Congressional Research Service, Library of Congress, "Insuring the Uninsured: Options and Analysis," October 1988, p. 85.

[9] *Ibid.*, pp. 84-85.

STATEMENT OF THE OLDER WOMEN'S LEAGUE

The Older Women's League (OWL) was founded in 1980 to address the concerns of midlife and older women, and presently has over 120 chapters across the country.

OWL appreciates Chairman Riegle's long-standing commitment to providing adequate health insurance to our nation's uninsured. Access to health care is also a number one priority for our members.

Women are disproportionately represented among the 37 million uninsured in the United States, and midlife women are less likely to be insured than men of the same age. While women over 65 are covered by Medicare, older women who have not yet reached Medicare eligibility are a particularly vulnerable population. Women are more likely than men to suffer from chronic conditions—men are more likely to have acute medical problems—and thus women have greater difficulty in obtaining health insurance at a later age. Without group health insurance, hundreds of thousands of midlife women with preexisting conditions are unable to obtain even individual coverage at any price.

One way to improve the availability of health insurance coverage to midlife and older women is to improve the protections provided by COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA allows beneficiaries of employer-provided group health plans to continue their group coverage by paying their own premiums for either 18 or 36 months after certain qualifying events, such as retirement, termination, or divorce, that would otherwise cause the employee and others on his or her plan to lose their health insurance.

OWL provides information and advice to many people with questions about COBRA coverage, as there are few resources available to people with these questions. Through this work, OWL is aware of the ways COBRA could be improved, both substantively and administratively, and of the services employees and their dependents need to gain the full benefits of the law.

There are several measures congress could take to improve COBRA coverage, and thus to decrease the number of uninsured older people.

I. COBRA COVERAGE FOR WIDOWS, WIDOWERS, AND DIVORCED SPOUSES OVER 55 YEARS OF AGE SHOULD EXTEND UP TO MEDICARE ENTITLEMENT

Presently five States—Illinois, New Hampshire, Rhode Island, Louisiana, and Minnesota provide unlimited continuation coverage for spouses over age 55 who would otherwise lose their group health insurance coverage due to the death of, or a divorce from, their spouse.[1] This coverage is extremely important to older women, who often cannot find even individual health insurance at any price. The 36 months of COBRA coverage received in the case of death or divorce are a benefit to these women, but for many this coverage will not be enough, only postponing the likely impoverishment of women who find themselves, at age 60, without health insurance. One woman in her late fifties called OWL with a question about COBRA, and stated that she had been turned down for individual health insurance by several major insurers, although her doctor told her there was nothing in her medical record to justify a denial.

Changing COBRA to allow divorced and widowed people over 55 to continue their group health insurance would greatly improve the level of health insurance coverage for those over 55. This would facilitate planning for retirement, essential to avoid poverty in old age: presently the inability to obtain health insurance makes retirement planning almost impossible, as a single medical problem can effectively impoverish an uninsured person.

II. CORRECT ARBITRARY DISTINCTIONS MADE BY COBRA FOR MEDICARE-ENTITLED RETIREES

If a person expecting to retire signs up for Medicare after retiring and losing their group health insurance, their spouse and dependents can get up to 36 months of COBRA coverage. If the same employee signs up for Medicare before retiring, however, their spouse and dependents can get only 18 months of continued coverage. This arbitrary difference can make an immense difference to older women, who are often younger than their retiring husbands of Medicare eligibility age (65).

The problem lies in the law's complexity, and in the technical definition of the qualifying event of Medicare entitlement. "Entitlement" for Medicare has been defined by the federal regulations as taking place when a person signs up for Medicare, whether they could receive benefits at that time or not. One person who contacted OWL for assistance signed up for Medicare before he was 65 intending his coverage under Medicare to begin upon his retirement months later. He paid for two months of COBRA coverage for himself and his spouse, but when he filed a claim, the insurance company returned his premiums and told him he was not eligible for COBRA because he was "eligible" for Medicare coverage. The notice of COBRA benefits given out by his employer (see attachment) does not provide adequate information about how to get the full benefit; instead it merely states that "dependents of an employee who . . . becomes entitled to Medicare will have the option of receiving continuation coverage for 36 months."

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[1] Minnesota and Rhode Island do not restrict this option to those over 55; New Hampshire and Rhode Island do not allow it in the case of death of the spouse, only in case of divorce; Louisiana and Minnesota allow it only in the case of death, not divorce.

This person had not signed up for Medicare Part B because he had believed he had those benefits through COBRA. Further, based on his Medicare signup date, his insurance company is now stating that the qualifying event leading to COBRA coverage was his retirement, as his entitlement to Medicare did not lead to his losing coverage, and that his spouse would only receive 18 months of continuation coverage. She has cancer, and is 35 months away from Medicare eligibility: she would be completely covered if he had received the 36 months of coverage promised to spouses and dependents of retired Medicare recipients.

Another employer, according to a person calling OWL for advice, published an article in the employee newsletter informing employees that they need not wait until retirement, or even until they were 65, to sign up for Medicare. The article, this person stated, did not mention the consequences of this action for COBRA coverage.

The confusion in the statute's interpretation requires retirees to jump through hoops in order to get the 36 months of continuation coverage for their spouses that COBRA allows retired Medicare recipients. As section 4(g) of the ADEA prevents group plans from terminating coverage due to Medicare entitlement, Medicare entitlement will never be an initial qualifying event. To get the 36 months of coverage supposedly allowed dependents of a Medicare-entitled retiree, employees must "game" the system by signing up for Medicare only after retirement.

The policies behind COBRA continuation coverage are not served by these arbitrary and confusing requirements. The little information that employers are required to provide employees does not begin to equip them with the knowledge needed to obtain the full benefit of this legislation. The loss of the additional 18 months of coverage is crucial to people in this age group, and employees and insurance companies have every incentive to exploit the ambiguities in the law in their favor.

III. PROVIDE BETTER INFORMATION AND ENFORCEMENT ASSISTANCE TO EMPLOYEES AND THEIR BENEFICIARIES

As the above example illustrates, employees, their spouses and dependents need more information about the workings of COBRA. The law is extremely complex, and employers are under no obligation to assist employees with obtaining COBRA coverage, or with understanding the law's provisions. OWL has been contacted by women going through divorce, a qualifying event under COBRA, who have sacrificed other considerations in settling their divorce in order to obtain the health benefits they were already entitled to under COBRA.

Presently, the Internal Revenue Service responds to consumer inquiries by sending a copy of the preliminary regulations and a list of user fees for obtaining an opinion on a case from the IRS. The Department of Labor's Division of Technical Assistance and Inquiries will try to respond to consumer inquiries, but few people are aware that they are giving assistance, and their small staff can do little to aid actual enforcement beyond sending a letter to employers describing sanctions. There is no agency set up to resolve disputes: people with questions about the law must be able to afford an attorney and the long wait for Federal court resolution of their case. Particularly when the right involved implies essential health benefits, speedy and fair resolution is essential.

OWL recommends that a COBRA hotline be set up to answer COBRA beneficiaries specific questions on the law, and to aid in enforcing the law. Further, a division of the Department of Labor should be granted the authority to resolve these disputes administratively, and an outreach program established to inform people of the law and its benefits.

IV. COVERAGE BY ANOTHER GROUP HEALTH PLAN SHOULD NOT END COBRA COVERAGE, AS THAT LEAVES PREEXISTING CONDITIONS UNCOVERED

One event terminating COBRA coverage is becoming covered under another group health plan. For people with chronic conditions, which are excluded from coverage as pre-existing conditions under most plans, changing health plans means a gap in coverage. COBRA can fill this gap. If a beneficiary is willing to cover the costs of two premiums, he or she should be allowed to continue coverage under the plan that covers his or her pre-existing condition, as well as begin coverage the new plan, to eventually establish coverage for pre-existing conditions under the new plan. This change would be especially important to pregnant women, as well as to older women.

OWL thanks Chairman Riegle for the opportunity to present these recommendations.

Attachment.

AFFILIATED FOOD STORES, INC.

NOTICE

To: All Employees and Their Spouses

Effective October 1, 1986, your health program will include an option for continuation of coverage as follows:

I. ELIGIBLE EMPLOYEES AND DEPENDENTS

A. Employees (and their dependents) who quit, are fired (other than by reason of the employee's gross misconduct), laid off or have a reduction in hours, will have the option of receiving continuation coverage for 18 months.
B. Dependents of an employee who dies, gets a divorce or legal separation, Or becomes entitled to Medicare will have the option of receiving continuation coverage for 36 months.
C. A dependent child who ceases to be a dependent child under the terms of the Plan will be offered continuation coverage for 36 months.
D. The beneficiary will be required to pay no more than 102 percent of the total premium charged to the company for your group coverage.

II. TERMINATION OF COVERAGE

Continuation coverage may terminate earlier than the 18 or 36 month cut-off date under the following circumstances:

A. If the required premium is not paid and received within 30 days of the due date each 1st of the month. (1st premium must be paid with the application.)
B. If the beneficiary becomes covered under another group health plan.
C. If the employee's ex-spouse remarries and the spouse becomes covered under another group health plan.

III. ELECTION PROCEDURES

A. A person who is eligible to receive continuation coverage must elect this coverage within 60 days of the date of one of the qualifying events noted in I. above.
B. Eligible employees and other beneficiaries are required to notify Personnel Department if the eligible employee becomes
    (1) Divorced or legally separated or
    (2) When a dependent child ceases to be a dependent child under the terms of the plan.

IV. CONVERSION OPTION

A. A conversion option which becomes operative after expiration of the continuation coverage, is provided if election of the conversion option is made within 30 days following the end of the continuation period.

U.S. CHAMBER OF COMMERCE

July 10, 1989.

HON. DONALD W. RIEGLE, JR., *Chairman,*
Subcommittee on Health for Families and the Uninsured,
Committee on Finance,
U.S. Senate,
Washington, DC

Dear Mr. Chairman: The U.S. Chamber of Commerce, the world's largest federation of businesses, chambers of commerce and trade and professional associations, offers its views on developing solutions to provide access to health care for all Americans.

The Chamber agrees with you, Mr. Chairman, that high-quality, affordable health care should be available for all Americans and their families. As health care costs climb nationally, the issue of access to health care has become inextricably linked with the issues of cost and quality. The Chamber believes that these three issues must be addressed in tandem in order to forge a consensus on a workable solution. Such an effort will require a partnership of the public and private sectors, with neither sector being asked to absorb financial burdens more appropriate to the other.

A number of approaches have been proposed to address the problem of the growing number of Americans without health insurance. Because the uninsured population is diverse, no single solution is appropriate. For example, requiring all employers to provide a specified package of benefits does not take into consideration the factors—primarily the high cost—that have prevented some businesses from providing coverage or the perverse consequences that mandating benefits could have for many of the working poor.

The Chamber believes that a multifaceted approach to health care access should be developed and supports immediate action to lessen the number of uninsured through a mix of public and private initiatives. In this regard, on June 14, the Chamber's Board of Directors approved a policy statement embracing the following proposals:

- **Medicaid should be expanded to address the needs of the poor and near/poor who do not have financial access to primary care coverage:**

  1. Assure basic Medicaid coverage to all Americans with Incomes below the Federal poverty level, restoring the original intent of this program and defining clearly the public sector's responsibility.
  2. Allow persons with incomes between 100 and 150 percent of the federal poverty level to purchase, for a sliding-scale premium, primary care coverage through Medicaid.
  3. Permit persons with incomes above the poverty level who have large medical expenses to "spend down" and become eligible to receive full Medicaid coverage once income is reduced to the Federal poverty level.
  4. To ease an individual's transition off welfare or Medicaid, provide states the option of paying Medicaid-eligible employees' share of premium and other costs when private employer-based coverage is available.

In recognition of state and Federal budget constraints, the Chamber supports various options for phasing-in expanded Medicaid coverage, with the following priorities: coverage for mothers and children, with the youngest children receiving greatest priority; eligibility for coverage based on percentage of poverty level beginning with the "poorest poor"; and coverage for primary care.

- **Individuals who are uninsurable because of medical problems should be able to purchase health insurance through state pools.**

As many as one million Americans are unable to purchase private health insurance because they are substandard health risks. The Chamber supports federal legislation that would require the establishment of state pools for uninsurable individuals, with losses financed by state general revenues or other broad-based funding. To date, 16 states have established such pools.

- **Expanded voluntary coverage through the workplace should be promoted through incentives and removal of disincentives.**

Approximately two-thirds of the uninsured population has some connection to the workplace (i.e., they are workers or workers' spouses or dependents). The Chamber is committed to finding ways to extend private, voluntary insurance coverage without reducing employment and supports the following proposals:

1. Self-employed persons and unincorporated firms should be given a 100 percent deduction for health benefits costs. Unincorporated firms are about half as likely as other companies to provide health-care coverage to owners and workers. Currently, these firms may deduct only 25 percent of these costs, and even this deduction will lapse at the end of 1989.

2. Multiple Employer Trusts (METs) should be encouraged. METs are group arrangements formed to help small firms obtain health care coverage on a more cost-effective basis than an individual firm might be able to obtain it. Use of improved cost containment, quality and appropriateness methods in these programs can make them affordable to a larger cross section of employers. However, numerous Federal and state regulatory impediments have discouraged the proliferation of these arrangements. If necessary, such impediments should be preempted by Federal action.

3. For those public or private employers unable to join a MET for whatever reason, risk pools should be made available as a means of achieving lower group rates and reducing administrative expenses. The formation of pools might be undertaken by a group of insurers acting together or with state or Federal support. Any losses from these pools should be shared fairly, according to who benefits from the insurance pool mechanism.

4. State-level benefit mandates and barriers to managed care programs should be preempted. More than 640 specific state mandates now require insurers to include particular benefits in health plans (e.g., mental health or chiropractic coverage), which make health-care benefits more costly to employers with insured plans. A study by the National Center for Policy Analysis estimates that as many as 9.3 million people—25 percent of the uninsured—lack coverage because of state mandates. Another study found that one in five small companies that did not offer health insurance in 1985 would have done so if their state's mandates were eliminated.

In addition to the state benefit mandates, there is increasing legislative activity at the state level that undercuts cost-containment efforts by limiting managed-care arrangements. For example, some measures would limit the formation of preferred provider arrangements or the provision of economic incentives to employees to select such arrangements. Such barriers to managed care should be removed by Federal or state action.

5. Federal benefit mandates should be repealed or simplified for employers.

- **The development of national medical practice standards to assure appropriate and effective care should be promoted.**

A significant percentage of services delivered in the U.S. health-care system is judged by researchers to be either inappropriate or ineffective. Further, research has shown wide variations in the use of procedures across different geographic regions with no apparent medical justification. The development of practice guidelines, review protocols and outcome-based assessments through a national effort led by physicians and scientists is the key to eliminating this degree of waste from the system. Use of such standards with due care by physicians should carry with it protection from unwarranted malpractice claims.

Mr. Chairman, the Chamber commends you for drawing attention to this critical issue and requests that its remarks be made part of the hearing record.

Sincerely,

ALBERT D. BOURLAND.

RESPONSES TO A REQUEST FOR COMMENTS BY SENATOR RIEGLE

ADOLESCENT HEALTH CENTER

To the members of the Senate Finance Subcommittee on Health. Thank you for allowing me to address your committee and voice my concerns and experiences of being involved with adolescent health care. As you well know, the goals of any governmentally supported social or welfare agency are to assist the citizenry in achieving through self-sufficiency a living standard which eliminate the need for public support and secondly, to meet the needs for societal services, within society and the family unit without the public provision thereof.

As these are generational goals, it is not feasible this year or this decade to achieve "self-sufficiency" for the disadvantaged children who have insufficient income to provide the basic necessities of life. Further, as technological changes occur, the demand for unskilled labor decreases. It becomes increasingly difficult for an illiterate or semi-educated person to obtain employment paying wages sufficient to enable him or her to support the family.

For these reasons, I feel that the comprehensive school-based health centers, such as those proposed and supported by the State of Michigan, are a logical and appropriate way in which to address these needs particularly on behalf of adolescents.

Demographic Description

Genesee County is located in south-central Michigan, seventy miles north of Detroit. The U.S. Bureau of Census indicated that in 1980, the county's population was 450,449, an increase of 6,000 since 1970. Of this total, approximately 43,500 fell in the age group of 12 to 18 years. Genesee County was typical of many older urban industrial communities with declining populations and tax base in the core city of Flint and growth in the surrounding suburban areas. The flight to the suburbs left Flint with an older, poorer population having a greater minority concentration during the first part of the 1980's.

The economy of Genesee County has always been heavily dependent on the auto industry. The national decline in auto sales, which began in the late 1970's, severely affected Flint, resulting in the city leading the nation's unemployment statistics several times.[1]

The U.S. Census estimates that Genesee County declined in population to approximately 440,000 by 1987. A natural increase of births over deaths added 28,000 to the population but migration reduced the number of residents by 38,400 during those seven years. The high migration rate has been caused mostly by young, white residents seeking employment outside the county. This trend may have slowed, but it is expected to persist at least through 1990.[2]

Indicators of the county's continuing economic problems are work force size, per capita income statistics and unemployment rate. From 1983 to 1988, Genesee County's total workforce dropped from 187,600 to 161,500, a change of 13.9%. Per capita income in Genesee County dropped from an average of $11,570 in 1980 to $7,951 in 1986; a change of 45.5%.[3] Unemployment rates, which shot up to 26.5% for Flint in November, 1982, were still at 12.2% for Genesee County in July, 1987 and rose to 18.2% in January, 1988 after a major plant closing. In January, 1989, Genesee County's unemployment rate was 12.7% with the jobless rate in Flint at 16.9%. This contrasts with a national unemployment rate of 5.3 to 5.4 for the same period of time.[5]

Health Problems

Whether or not such economic conditions directly lead to more health problems and a greater demand for health care, has not been thoroughly verified. However, the State Office of Substance Abuse Services reports, "It is believed that the stress of loss of employment leads to abuse of substances and that the need for such services increases during difficulty economical times."[6]

Other major health issues in Genesee County include infant mortality and teenage pregnancy. Ten years ago, Genesee County's teenage pregnancy rate was 22% higher than the state average, ranking second only to Wayne County and metropolitan Detroit.[7] Between 1980 and 1986, the overall birthrate to teenage mothers has declined from 1,305 to 1,055. Two-thirds of this decline can be attributed to the fact that there is a smaller number of females in the 15 to 19 year age group than prior to 1980. One-third of the reduction is due to an actual drop in the teenage birthrate reported in Genesee County as well as the rest of Michigan. Greater awareness and use of family planning methods and/or reduction of sexual activity through educational services may account for this decline.[8]

Teenage mothers are at a greater risk of giving birth to low birth-weight babies, a critical factor in infant mortality. Statistics compiled by the Michigan Department of Public Health indicate that Flint and Genesee County had extremely high infant mortality rates, in 1981 during the worst of the economic recession. Genesee County's infant mortality rate of 15.5 and Flint infant mortality rate of 19.7 far exceeded the state average of 13.2 in 1981. Michigan ranked as the 36th worst of 50 states for infant mortality at that time.[9]

From 1982 to 1984, Genesee County's overall infant mortality rate improved, averaging 12.3 but the average infant mortality rate for mothers under 20 was 17.9. The infant mortality rate for non-white mothers under age 20 was even higher.[10]

In addition to teenage pregnancy, the youth of Genesee County were and are still at-risk of multiple health problems, including mental illness, violence, gonorrhea, substance abuse and AIDS.

Adolescent pregnancy continues to pose a threat to the well being of Genesee County. Between 1980 and 1986 it was noted the overall birthrate for adolescents declined due to a decline in the number of adolescent females.[11] In spite of this decline, the county continues to report a higher incidence than the state norm and there has been a noted trend of an increase in younger adolescent mothers (under age 14).[12]

The economic decline in Genesee County has resulted in an increase in unemployment for at-risk minority youth. This loss of personal income results in a lack of access to transportation to service providers and money to purchase services. The fact that up to one third of low income adolescents lose their medicaid eligibility every year compounds this inability to secure health related services.[13]

In addition, Since 1984, Flint Community Schools has had to close 8 schools due to rising costs, declining enrollment and changes in financing mechansims. The school system has also had to lay off teachers and other staff, reducing the number of school nurses to 3 who now have to cover the entire district. The boundaries of Northwestern High School district have changed but the economic status of its residents has not improved. Approximately 41% of the entire school district consists of children from families on Aid to Families of Dependent Children.

With the establishment of the Adolescent Health Center, in October of 1984 to December of 1986, a total of 11,767 persons have made contact with the center, and of these, 8,055 have received health education for all services combined. These health education programs have been designed to treat the whole individual, not just certain parts, with teen pregnancy being identified as the major health risk. The center has devoted a moderate segment of its efforts to combat this problem. What we see in Flint, contary to popular belief that all young mothers choose to become pregnant, is a group of young people who feel impotent, and unable to direct their lives or control their circumstances. They allow themselves to become victims and accept the consequences.

Flint's program has developed an inclusive plan of intervention, with the long-term goal being to help each individual achieve his or her maximum potential. To establish a mutual and trusting relationship the agency must consistently meet the needs of the community as well. Programs are aimed at the reason young people engage in sexual relationships, for example, low self-esteem, the lack of communication between the sexes, the lack of direction from elders, boredom, etc. In the summer, when time for teens is most available, the Adolescent

Health Center makes the most use of this time. The calender is filled with programs that are entertaining as well as useful for learning. Programs such as the Health Awareness Flim Festivals, which increases the awareness of the importance of good health habits, overnight retreats that are designed to assist in problem solving, decision-making and communication or short workshops, such as Child Abuse-What is it? and Courtship & Dating.

Adolescents have identified "cost and access problems" as deterants to utilizing family planning services.[14] This population has also demonstrated a reluctance to utilize adult oriented family planning services. Edwards, Steinman, Arnold, Hokanson (1980) have identified a lack of available services for adolescents as a contributing factor for adolescent pregnancy.[15] The influence of scarse financial resources and unemployment was also cited in a local study of Genesee County adolescents. (McKinney/Tippit) This study also indicated state legislation banning school based clinics from providing family planning services has severely limited local efforts to curtail adolescent pregnancy. It is recommended that indigent care financing proposals should cover ambulatory services if they are to benefit most young people.[16] Ralph Tyler, a noted educator has stated, "You can tell you are being educated if your options are increasing." School based centers hlep to increase the options of its young clients without making decisions for them. The centers do this through education, support and encouragement.

When more financial resources are allocated to school based programs so that the state model may be fully implemented, I feel certain that the resources that are now available to the Flint area youth will become a reality as well, to every young person in the State of Michigan.

Please remember the goals and philosophy of adolescent health centers and that is:

"To increase awareness of options, not make decision, to educate, to support, and to encourage the clients to realize the infinite choices available."

FOOTNOTES

1. Bailus Walker, Jr., Ph.D., Impact of Unemployment on the Health of Mothers and Children in Michigan, Recommendations for the Nation, January, 1983, p. 4.
2. Kurt Gorwitz, Sc.D., Marvin McKinney, Ph.D., and Susan Tippett, A Profile of Adolescent Pregnancy and Parenting, Genesee County, Mott Children's Health Center, May, 1988, p. 3.
3. Source: Michigan Office of Management and Budget. Information compiled and provided courtesy of Stevan Nikoloff, Director of Research, Flint Community Schools.
4. Walker, Ibid, p. 9.
5. "Jobless rate climbs 2.3%," Flint Journal, March 9, 1989, p. C-1 and "Jobless rate 4.5%; lowest in 15 years," Flint Journal, March 10, 1989, p. A-11.
6. Michigan Office of Substance Abuse Services, Annual Evaluation Report, 1979-80, p. 60. The same page notes that the 21-25 age group were the largest age group listed as unemployed but in the work force to be admitted to substance abuse treatment programs in the state.
7. "Study links idled rate with increase in male suicides," Flint Journal, October 25, 1982, p. D-4.
8. "This School Copes with Teenage Pregnancy," Flint Journal, June 12, 1983, p. A-2.
9. Gorwicz, McKinney and Tippett, Ibid, p. 4-5.
10. Infant Deaths in Michigan, Analysis and Recommendations, Michigan Department of Public Health, 1982, p. 1-5.
11. Gorwitz, McKinney, and Tippett, pp. 57,70.
12. U.S. Census, information courtesy of Stevan Nikoloff.

2037 Streader Drive
West Bloomfield, MI 48033

Mr. Donald W. Riegle, Jr.
Century Center Bldg., 3rd Floor
Warren, MI 48093

Dear Mr. Riegle:

Thank you for your recent notification of the hearing by the Senate Finance Subcommittee on Health. I will be unable to attend but wanted to let you know of my concern on the issue of healthcare. Specifically, the ability of a Person with a "pre existing" condition to obtain health care at a reasonable cost is very difficult and I question wether it should be.

Why such a modern and industrial country can allow someone who is willing to pay for health insurance to go without is hard to understand. Even to insure some things and not others (partial coverage) and let a person suffer from not having enough medical treatment seems like a underdeveloped country approach.

Please consider an approach to health care that would allow for anyone to be insured that wanted to be and one where they would not have to lose their right arm to get it.

Thank you for listening.

Sincerelly

Patrick D Aerts
Patrick D. Aerts

ALLIANCE FOR MENTAL HEALTH SERVICES

FROM: CLAUDIA GOLD
EXECUTIVE DIRECTOR

The Alliance For Mental Health Services, working cooperatively with representatives of the mental health professions (psychiatry, psychology, psychoanalysis, social work and nursing) and mental health advocacy groups and service providers listed above is concerned about the quality of public and private mental health services. Necessary maintenance and expansion of mental health services for all citizens and excellent professional training, research and education is crucial. We are concerned about the plight of the uninsured in America; access to health care should be the right of every citizen. Thank you for the opportunity to testify today.

We are pleased that the committee is taking up the issue of insurance coverage for all American citizens. When final decisions are made regarding such coverage we feel that all persons and conditions must be covered equitably. We are now in a period of rationing of medical care in the United States which is unacceptable. In your deliberations, we ask that you not allow the stigma often connected with mental health care to be present in proposed national coverage for the uninsured; coverage for mental illness must be at least equal to that for any other condition.

Public institutions for mentally ill adults and children are designed to provide service to the most severely impaired; their funding must correspond with the existing and expanding patient case load. Hospitals cannot be just inpatient service providers; they must have a broad spectrum of services and training with all treatment modalities available. It is necessary to provide the services of contractual service professionals, who bring additional sophisticated training to the hospitals.

Private institutions often find themselves treating patients whose severely limited mental health coverage does not allow a full course of treatment to be provided, much to the detriment of the patient. Those institutions often find themselves incurring great financial losses when coverage is disallowed for already delivered mental health care. The often overloaded and understaffed public hospital system then often provides care for those whose coverage has run out. Families are often financially devastated when private insurance does not adequately cover the natural course of an illness.

The public Community Mental Health system whose staff is already overloaded, treats many uninsured clients. Often C.M.H. Centers are expected to treat patients whose pathology is beyond their capacity to serve. To allow such limited treatment in centers which frequently have extended waiting lists for clients is unacceptable.

Essentially, the provision of insurance for those uninsured, can increase quality services. Existing public mental health programs which have already suffered reductions in this time of economic restrictions, require additional funding in order to provide quality care. We must create an atmosphere attractive to professional students and to staff existing institutions and community based treatment centers with qualified personnel. Institutions and private practitioners must be allowed to treat patients throughout the course of illness. We ask the Committee to extend the funding of federal health programs to cover the uninsured mentally ill. We are particularly concerned that mental health coverage be extended at levels that recognize the unique needs of the mental health patient. Recommendations that allow service provision, training, education and research, which is the hope of the future, to be maintained and expanded is necessary. We are pleased with the present concern for the uninsured and add the recommendation of our organization that coverage be provided.

Honorable Donald W. Riegle, Jr.
United States Senator
1805 McNamara Bldg.
Detroit, MI 48226

Dear Senator Riegle: June 25, 1989

This letter is in reply to your notification of the June 28, 1989 hearing by the Senate Finance Subcommittee on Health. I am not able to attend because I am handicapped and do not have adequate transportation.

I have a disease known as ankylosing spondylitis, which is an arthritic condition of the spine. Advanced spondylitis causes severe pain, and results is a spine frozen by calcium. Compounding this, I also have a heart condition known as Wolff-Parkinson-White syndrome (WPW) which characteristically produces life threatening arrhythmias. I was forced to retire five years ago and have not been able to afford professional medical treatment since. Were it not for my expertise in physiology, I would surely have died four years ago.

Fifteen of my twenty-some adult working years were spent working as a medical research scientist. I am well published, and some of my past research projects are now standard medical treatment. This training, and the FDA's relaxation of some ancient drug laws, has allowed me to treat myself. Certainly, this quality of treatment is not equal to that of a modern hospital, however it does keep me alive.

I am writing because, as a (past) medical professional, I can state beyond a doubt that any person in my situation not trained in medicine would not have survived.... Proper health care is that important! Yet, Social Security disability requires many months of waiting before it begins -- and then, it's another two full years until the medical starts. This, Sir, is for someone who has already been confirmed by the Social Security physicians as medically disabled! My Medicare Health Insurance has not started yet.

And there's yet another problem I have noticed: I have barley managed to make ends meet here. When the Health Insurance starts, I will have to pay for it. I eat, but not really well. So, what do I give up to pay for the insurance? It looks like I'll be moving out of my very small house and into an even smaller apartment as a trade-off for the Medicare. On the other hand, had I been receiving proper medical treatment, I would probably be back to work now.

Then there is the problem of the "Medicare Mills:" It is my experience that most Medicare clinics are little more than legal rip-offs! The Medicare patient is seen by an unsupervised first or second year residant -- who is encouraged to "order a complete battery of tests" and get to the next patient. The more tests ordered, the more money the hospital collects from Medicare. And so it goes -- inadequate treatment, many background tests, a big bill to Medicare, and the patient quickly out the door "until the test results are back."

Proper diagnosis should be done by taking a complete history and performing a complete physical examination. This takes considerably more than the five or ten minutes allowed a Medicare patient. In most cases, the "tests" should only be used sparingly to back up the diagnosis -- but tests generate the most income for the clinic!

One case in point is a man who went to a clinic for pain in his leg, radiating from the hip. Chances are 99% that he has a pinched nerve in there somewhere -- a common condition known as sciatica. The physician ordered an electromyogram, X-Rays, and a CAT scan. Because the CAT scan was ordered they didn't need the X-Rays, but they were ordered anyway. The gentleman also complained of headaches. Therefore, the physician ordered a CAT scan and an MRI of the head. All was billed to Medicare.

Of course he had a headache! -- headaches are a very common side effect of constant pain! Medicare was charged thousands of dollars, and the physician at the Medicare Mill received some big kick-backs on the tests. All this from a ten minute patient visit -- and the patient is still in pain and knows nothing more about his condition than he did when he went in. I have seen this type of "Medical Treatment" many hundreds of times in the past few years.

Fraud, Waste and Abuse in the Medicare Industry run considerably deeper than the pacemaker scandal of a few years ago. And, Medicare's new billing methods did little to slow it down.

Five years ago I was caught in a catch 22 situation which was the direct cause of my present situation. I knew that I would have to take at least a temporary retirement because the spondylitis was getting so bad that the hospital's insurance companies would not insure me any longer. However, my research was going so well that I put retirement off for as long as I possibly could. I also saved money to pay for Blue Cross while I was retired.

Two years earlier, I started a small Subchapter S company with the intent of marketing (during my retirement) some of the medical electronic equipment I invented for research. In comes IRS!

IRS said that I did not file a certain paper for the company. I informed them that I did, in fact, file the forms. Actually, I still remember calling the local IRS office to ask for the forms -- and calling them a second time to ask exactly how they wanted me to fill them out for my specific circumstances. And, I remember mailing the forms.

Three years later, IRS said I did not file the forms and owed them many thousands of dollars. I said I filed them and was told "We don't care, we do not have them." People were with me when I filled out and mailed the forms, I informed them, and said that any court in the world would believe it. At that time, I did not know that the IRS was excused from following the American Rules of Law -- that the Constitution did not apply to them.... They didn't take me to court. Unexpectedly, they just took all of my money, including what I had set aside for health insurance! Then, when confronted, they said "Well then, get a lawyer."

I still have work I would like to complete -- I have more to offer. But, due to lack of proper medical treatment and medications, here I sit.

The best suggestion I can offer the Finance Subcommittee is to check the abuse and fraud in the Medicare industry. One method would be to compare charges for like treatment in rural areas. I would bet that country doctors provide better treatment for one-tenth the diagnostic cost to Medicare. There are many, many good reasons for this....

Sincerely,

Douglas R. Allor
(313)881-4225
5235 Neff
Detroit, MI 48224

amosaa

Allegan, Muskegon, Ottawa Substance Abuse Agency

324 WASHINGTON STREET • P.O. BOX 268 • GRAND HAVEN, MICHIGAN 49417 • PHONE (616) 846-6720

OREL D. CALLAHAN, Ph.D., *Executive Director*

June 23, 1989

Honorable Donald W. Riegle, Jr.
United States Senate
700 Washington Square Building
109 W. Michigan Avenue
Lansing, Michigan 48933

Dear Senator Riegle,

Thank you for notifying me of the Senate Finance Subcomittee hearing scheduled for June 28, 1989 dealing with access to health care for uninsured individuals. Although prior committments prohibit my attending the hearing, I concur with you that this is a very important issue and thank you for providing the opportunity to provide written testimony. Lack of access to substance abuse services is damaging and expensive to individuals and society alike.

Lack of access to substance abuse services is a multi-facted problem, both for individuals and society. Societally, as you are aware, substance abuse or intemperate substance use is at the root of a wide variety of problems such as child abuse, broken families, crime, accidental death, lowered productivity, unemployment, and over utilization of the rest of the health care system. This, of course, drives up health care costs and exacerbates the access problem for everyone. Individually, substance abuse services are even less available to the uninsured that most other forms of medical care. There are fewer treatment facilities and fewer funding options at those facilities. Untreated or unattended, substance abuse inevitably leads to excessive demands for remedial services from the rest of the health care system. Then problems that were not attended to because of a lack of substance abuse treatment are dealt with for far more money and with a poorer prognosis. In addition, programs designed to assist citizens overcome poverty or other problems are often thwarted because people can not make productive use of the services due to their substance abuse.

BOARD OF DIRECTORS

DON HUFF, Allegan
BILL GILL, Muskegon
JOHN HALMOND, Muskegon
JESSIE DALMAN, Ottawa
DAVID VANDERKOOI, Ottawa

Our experience indicates that there are several populations that have inadequate access. One group, of course, consists of the unemployed poor. A second group consists of regular employees in companies that either do not have insurance or whose insurance does not cover substance abuse services. A third, and growing, group consists of temporary employees who are hired for extended periods of time without fringe benefits available to regular employees of the same employer. While additional resources are needed, they would not, by themselves, fully solve the problem. Current reimbursement practices such as preferred provider arrangements were designed to control costs; but they often have an opposite effect. Frequently, only large providers of care are able to compete for preferred contracts because of capricious and unrealistic accreditation standards. When smaller providers or providers of specialized services are driven out of business, costs escalate. The tendency is to preserve expensive treament modalities or protocols that are not necessarily effective or needed by all individuals. Our system selects for the most expensive and elaborate treatment and this is not always commensurate with the most appropriate treatment or improving access.

It is a complex problem and I can't envision solutions that can be fully developed in a letter; but certain areas can be identified that need careful scrutiny. One, reimbursement policies should not limit treatment modalities or favor one form over another. A full range of services at all levels of intensiy should be available to ensure that the most appropriate and least expensive options are available. Two, our policies should deal with physical access as well as financial access. That is, policies should encourage more providers in more locations. Three, two track systems, one for the publically funded and another for the private pay, should be discouraged by requiring all providers to see some minimum percentage of clients who are funded by public funds. Simplification of the system should be encouraged by consolidating public funding sources into a single entity and treating it like an insurance company. Standardization of reporting and record keeping could save money and make more of our existing resources available for improving access. Evaluation of treatment outcomes and quality assurance are necessary both to protect current patient rights and ensure improvement in services to future patients.

Again, thank you for this opportunity to comment on these issues. If I can ever be of further assistance please call on me.

Sincerely,

Orel D. Callahan

Orel D. Callahan, Ph.D.
Executive Director

June 28, 1989

Mrs. Paullette R. Anderson
24640 Ridgedale
Oak Park, MI 48237

Senator Donald W. Riegle, Jr.
United States Senate
Washington, DC 20510

Dear Senator Riegle:

I wish to communicate to all legislative officials present today at this Senate Finance Subcommittee on Health how inaccessible, discriminatory, extremely expensive and unaffordable quality health insurance is in Michigan and the health insurance problems we as a family have experienced.

We are a family of four. My husband is self-employed and operates his own mobile wash business. I am a full-time homemaker and mother of two. We live in a modest home in Oak Park, Michigan.

We pay $350 per month for health insurance with Blue Cross/Blue Shield. Our health insurance is $19 cheaper than our house note. The non-groupplan we are subscribed under is suppose to be the best plan Blue Cross/Blue Shield offers. However, it does not cover office visits prescription, immunizations, and only partially covers x-rays, and lab work. By the time we add these additional expenses to the over-priced premium, we have many times paid $500 a month on health care!

This is social outrage and extremely unfair to the consumers!

When shopping around for more affordable and comprehensive health insurance the problems got worse. No major HMO in the state of Michigan offers a non-group plan. One HMO has a pre-recorded message stating that "we do not offer non-group coverage". Furthermore, very few other insurance companies offer a health care plan and the ones that do offer very minimal coverage and are very expensive for the average low to middle income person. Needless to say, this situation has put an enormous financial strain on our family and I am sure on many other individuals and families as well.

Quality health insurance should be accessible and affordable to citizens at all economic levels-- not just the corporate working class and the very poor. Our current situation shuts out quality health care for the self-employed, some senior citizens, the low to middle income, minimum wage earners, the unemployed, the underemployed and others. In most cases, doctors and hospitals will not even see you if you don't have an active health insurance plan and many won't except certain insurances. You are treated as if you have the plague-- no one wants to touch you. No affordable and quality health insurance plan is available to millions of Americans.

It is my recommendation today that all health insurance companies, including HMO's discontinue their discriminatory pratice of shuting out non-group citizens from obtaining affordable and quaslity health insurance by:

**Offering a comparable quality non-group plan to individuals at an affordable price and cease to financially penalize individuals who are not a part of a company group.

The federal government should offer an affordable, quality health insurance plan for any American citizen to subscribe.

This is an urgent and immediate problem which I hope and pray will receive major and immediate attention and action in the very near future.

If I may elaborate or supply you with any additional imformation, please contact me at the above stated address or at (313) 545-0391.

Respectfully,

Paullette R Anderson

Paullette R. Anderson

/pra

6-30-89

Dear Donald W. Riegle Jr

I am thankful for your hearing on health insurance in the last two years health insurance and care has become vary unaffordable.

I am unemployed and have been paying for my own health insurance. In the last two years the cost of my health insurance will have doubled. Because of the three rate increases.

I am at the point that I can not longer afford health insurance. Because of the vary high cost I will be out of health insurance after July 30

I am not entitled to apply for Medicaid because of the clauses that say you must be totally broke

Their are many unemployed and disabled people who have to live without health insurance because they can not afford to pay for health insurance on their own.

These problems can be solved if our leaders are willing to cooperate

Sincerely

Mr. Anthony Anikewich
25805 Hayes
Warren, MI. 48089

PS. Please let me hear from you soon about the health insurance problems

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: William G Anderson, D.O.

Address 12523 Third Ave
Highland Park, Mi 48203

Representing : Detroit Osteopathic Hospital Corp

****

I invite you to attach a prepared statement or to submit your written testimony:

There are physicians and hospitals committed to areas of greatest need (urban and rural) that are denied the opportunity to provide health care because of no source or insufficient source of compensation.

Physicians are avoiding establishing practices in these needy areas and hospitals are closing.

Without a mandated, universal program including private and public sectors the situation will continue to deteriorate and needless suffering and deaths will continue

Ann
Arbor
**Center
for
Independent
Living,
Inc.**

June 27, 1989

Senator Don Riegle
United States Senate
Washington, DC 20510

Dear Senator Riegle:

I have worked with people with disabilities for over ten years. During this time it has become obvious that access to affordable health care is a major issue to many people with disabilities. The following is a description of the situations people are faced with in attempting to obtain health insurance.

A woman with post-polio works for a small (less than 10 employees) non-profit agency. The agency has a group insurance policy with a private insurance company. However, the policy has a "pre-existing condition" clause and will not provide health insurance coverage to an employee with post-polio. The agency states they cannot afford Blue Cross/ Blue Shield of Michigan's rates which would cover the disability characteristic. Since this woman with a post-polio characteristic wants to work, she continues to do so without health insurance coverage, taking the risk of large medical bills or denial of medical services because she has no insurance.

A man with a spinal cord injury is offered a part-time job at a local business. He will earn much more money at his part-time job than he receives in SSDI. However, he will lose his eligibility for Medicare and will not be covered with a health insurance policy as a part-time employee. This man really wants to work and could work, but does not because it would

2568 Packard Rd., Ann Arbor, Michigan 48104-6831 · (313) 971-0277 · (TDD) 971-0310

A Washtenaw United Way Participating Agency

mean he would have no health insurance coverage and he is understandably afraid to take that risk.

A woman who is married and has rheumatoid arthritis maintains her home. Her husband's place of employment has a health insurance policy that contains a "pre-existing condition" clause for dependents. This woman has regular hospital appointments and requires fairly expensive, prescribed medication. None of the expenses nor any hospitalizations are covered by her husband's health insurance policy. This woman is not eligible for Medicaid because her husband's income exceeds the income restrictions of Medicaid, even though her husband's income is not substantially above the poverty level.

The lack of adequate health care coverage for people with disabilities who can and want to work is a national disgrace. There remains a strong fear and distrust among people with disabilities who have Medicare and Medicaid coverage that the government and society is not fully committed to providing adequate health care coverage for all people.

As a result, people with disabilities are fearful of jeopardizing the few health care benefits that they already have by seeking employment and placing these benefits at risk.

People who are able to work and want to work should not be denied this right by the very system that is in place to serve them.

Sincerely,

RoAnne Chaney

RoAnne Chaney
Program Coordinator

ARAB-AMERICAN AND CHALDEAN COMMUNITIES SOCIAL SERVICES COUNCIL, INC.
28551 Southfield Road
Suite 204
Lathrup Village, Michigan 48076
(313) 559-1990

We are representing the Arab-American and Chaldean Communities Social Services Council, a nonprofit organization that is committed to promote the health, education, psychological and other human services to the Arabic and Chaldean communities in Southeast Michigan.

Through our work since 1979, we have encountered countless problems facing this community, especially in receiving adequate health care. The road blocks to the access of health care are many. To name a few:

1. Lanuage barriers; many of the new immigrants lack adequate proficiency in the English language.
2. Lack of transportation.
3. Lack of knowledge of the services which results in the underutilization of these services that are available to them.
4. Lack of preventive health measures.
5. Intimidation by the large clinics and hospitals.
6. Lack of health insurance.

Furthermore, we find only some of the new immigrants who are not working have medicaid or are receiving some kind of general assistance.

Our concerns are:

1. The working poor whose medicaid benefits are cut with their welfare payments as soon as they start work and yet on their small wages cannot afford to buy any kind of medical insurance. This segment of the population is going without any coverage on medical care, and when in need of health care, they postpone going to the doctor because of inability to pay and do not access any health care agency for lack of funds. We are very concerned about the consequences of this neglect which we feel will attribute to and exaggerate the difference in statistics between the majority and minority health status in Michigan. Furthmore, many people who are on welfare are avoiding finding low paying jobs because thay are afraid that their health benefits will be cut, which is costing the state even more.

Our recommendation is to keep the medical benefits for the working poor even if their other benefits, such as welfare payments, food stamps, etc., are cut. This will encourage them to find jobs and yet give them the security that they can still access health care.

2. The older generation: in our culture the husband is usually several years older than his wife and when he reaches age 65, is eligible for medicare and his wife, who maybe 58 years old, is left without any insurance at a time when she needs it most. Our recommendation is to keep the wife's medical benefits.

3. Individuals on G/A who are of Arab-Chaldean origin are filing countless complaints against the health care they are receiving from the designated clinics, such as long delays in getting appointments, difficulty in communication and lack of transportation.

Our recommendation is that these individuals be assigned to clinics staffed by Arabic doctors, receptionists and nurses who can communicate with them and make them feel less intimidated.

**Association for
Children's
Mental
Health**

Help and Hope for the Future...

Charles Ramsey, President
Martha Ellen, 1st Vice-President
Juliet Crawford, 2nd Vice-President
Paul Jordan, Secretary
Cindy Fales, Treasurer

855 Grove Street
East Lansing, MI 48823
517-336-7222, 336-7223
Gail Allen, Director

2420 Cranden Drive, S.E.
Grand Rapids, MI 49506
616-243-0050
Rosemary Allen, Director

June 27, 1989

The Honorable Donald Riegle, Jr.
700 Washington Square Building
109 West Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

On behalf of emotionally disturbed children, we would like to thank you for your outstanding efforts to ensure health care for the uninsured. Because the Association for Children's Mental Health is primarily involved in mental health issues, we were pleased to receive your notice of the hearings scheduled by the Senate Finance Subcommittee on Health. Because neither of us was free to attend the June 28 hearing, we would like to share with you our thoughts and concerns.

High quality physical and mental health services should be available to both children and adults. As co-directors of ACMH, we urge you and your subcommittee to recommend that all families with children who are experiencing serious emotional disturbance be ensured appropriate mental health services under the law.

Uninsured families are not families who can spend $45 per day for foster care, $90 or more per day for residential care, or $400 or more per day for psychiatric hospital care. They most often cannot afford even $40 per week for outpatient therapy. Thus the uninsured child fails to receive the critically important mental health treatment which can prevent serious problems in adulthood and bring a sense of purpose and dignity to his/her life. Even insured families are unable to obtain reimbursement for specific treatment services such as foster care, respite care, and residential treatment.

Each child who lives with the fear, trauma, and rejection, which accompany mental illness, must be ensured appropriate services. Equally important, their families must receive help and hope.

As advocates for mentally ill children, we see the ravages of serious emotional disturbance on families. The chronic crisis and uncertainty are devastating. Families should not also be forced to face federal and state agencies in an uphill, often unsuccessful battle to obtain services for their child and themselves.

This voiceless population of children needs advocates in the legislature who speak to their needs and those of their family. No child or family should be without treatment services. Failure on the part of our country's leaders to provide funding for these services will ultimately result in costlier services imposed by our penal system. It is a national tragedy that we pay to contain the symptoms of emotional disturbance but fail to provide resources while there is a reasonable chance for rehabilitation and successful integration in the home, school, and community settings.

If ACMH can ever be of assistance to you or your staff, please do not hesitate to contact our office. We highly commend your hearings on health care matters and look forward to future communication with you regarding this crucial issue in the future. If we can furnish information which would be helpful to your mission, please contact the ACMH office at anytime.

Sincerely,

Gail Allen (gk)

Gail Allen

Rosemary Allen (gk)

Rosemary Allen

gk

Senate Finance Subcommittee on Health
c/o St. Johns Armenian Church Cultural Hall
22001 Northwestern Highway
Southfield, Michigan

Honorable Senate Subcommittee Members:

I appreciate being notified of the Senate Finance Subcommittee on Health hearing, to be held on June 28, in Southfield. Being so close to my home, it is unfortunate that I cannot attend the hearing, but I submit this written testimony of several concerns I have about health services and their availability in my community and in the country.

To begin with, I strongly support the position that every person in America should have readily accessible, high quality health care for whichever health problem the person has, without regard to the individual's capacity to pay for the medical services and supplies. Such a national position is necessary on both humane and economically sound grounds. Untended health problems can have no other effect than to drain and deteriorate people to a condition of lower or non-productivity, and to escalate the health cost care of the person's ultimately worsened health condition. Such neglect compares to failing to feed children properly, then being required to bear the much greater expenses of their physical and mental underdevelopment and their incapacity to become better or at all participating, productive, well-adjusted citizens.

My personal concern is that I myself have been in need of medical attention for many years, but I have been unable to afford it, aside from other very serious barriers to my receiving proper and necessary health care. In January, 1979, I sought medical attention for chronic and debilitating health problems. I paid $52.00 to obtain a throat culture analysis and two prescriptions. I was advised to return for further examination, and that if certain tests would be recommended, it would be necessary that I obtain them from a hospital. I could not afford to have the prescriptions filled, nor to return to the clinic for further diagnoses. I strongly suspect that I needed the hospital testings, but I knew the fees would be out of the question for me. The result has been that I have continued without my debilitating condition being corrected.

I am unable to work, and am only very poorly taking care of critically important business that I am compelled to tend to myself. Medicaid cannot resolve the issue because the strings attached to receiving welfare are unacceptable to myself, beside other difficulties associated with my particular circumstances that bar my receiving, or even being eligible for, Medicaid benefits.

I applied for Social Security benefits, but my same particular difficulties have rendered me ineligible for receiving these benefits .

Without going into my particular difficulties, which are extensive and highly complicated, suffice it to say that I have been denied proper, direly needed medical attention for seventeen years, which has resulted in catastrophic health harms and other losses to myself, and which caused me to deteriorate into a physical collapse fourteen years ago. I should not have been working from the time of the injury I sustained seventeen years ago. A lack of insurance has not always been my problem, since I had full-coverage insurance when injured and for as long as I worked. My problem includes a supervision of physicians to require them to provide me with the medical care I need. Since I no longer have insurance, my problem now includes some means of paying for the care I need. Had I funds for diagnosis and treatment, I would speak with a hospital administrator in order to attempt to secure some accounting of a physician of his/her servicing of my medical needs. Locating an ethical physician is a matter I do not know how to achieve. There must be some physicians who are ethical, but I have not found any since 1977 when I was severely injured. Under the circumstances, it may be impossible for me to even secure a medical cure, or at least a diagnosis,of my maladies. Without some financial resource. I cannot even inquire about it.

After deteriorating to the point of extreme pain and illnesses, and after many years in bed, my health began improving, but never to the point of recovery or to my being able to work even part-time. Whether or not Mother Nature will ultimately prevail in my favor, I do not know. But they have been a very long and devastating seventeen years waiting for her, and that wait is a condemnation of those who have required that I suffer so badly with illnesses that physicians could have cured, or could have relieved the pain of, seventeen years ago had they simply chosen to do so. They can choose to cure me now if they will, but I can't pay them to do it, and they will need more than their own initiative to make that choice.

Medical care must be made available to all in need, without prerequisites (such as requiring a person to submit to the welfare program) being made upon the destitute person before they are eligible to receive the medical care, and physicians must be supervised to the extent that they cannot determine,according to their own whim, who will receive care for medical needs and who will be denied care for medical needs, .

My particular circumstances are not an isolated incidence of the destitute not having proper and necessary medical care. Among the devastations I have suffered as a result of untended serious illnesses, has been the disrepair of my home to the extent that my house is literally falling down. A friend has very generously helped me repair one of the major damages to my house. My friend hired a young man who, I am sure, has been out of work quite consistently. I noticed the first day that he had some kind of congestion, and he was losing his voice. He did not work energetically, but he worked for approximately four hours. A few days later my friend and the young man returned to my home. The man's congestion was not improved, and seemed some worse. After about four hours of work, I could see this six foot, six inch man was physically depleted. He is in his early twenties. I do not know how serious his illness is, but there is something significantly wrong when a very young man cannot work four hours without becoming depleted. I know he cannot afford medical care if he needs its. I suspect he also cannot afford food. He is very thin. Whichever the problem, society is losing theyouth and strength of that very young man. He was willing to learn and do the work, but his stamina was very low, and he was ready to stop after only a half day's work.

Another concern of mine for those in need or proper health care is that of indigent mentally ill persons. I recently heard a short blurp on the radio that the state of Michigan has hired nurses and will provide better care for these patients. I do not know how much of an improvement these services are, as I heard only the quick blurp. I do not know how many patients per nurse there are, or what the "better care" is, but at least it is encouraging to hear something is being done.

As much needed as these improvements, is the removal of the indigent mentally ill from the dungeons the state referss to as psychiatric hospitals. These barren, depressing, dehumanizing holding pens would be a serious detriment to the psyche of mentally healthy persons, and are all the worse for the psyches of mentally ill persons, whose inherent misery is significantly aggravated by the deplorable and degrading environments of state institutions.

The only genuine remedy that will provide the indigent mentally ill with quality mental health care would be to integrate them into actual hospitals which care for mentally ill persons who have the insurance or other financial means to pay for actual and quality care. Financially capable patients, or their families, can demand that necessary services be provided. Indigent mentally ill persons cannot demand anything, and many (probably most) of them have no families to protect them from inadequate, incompetent or absent care, or even from abuse. I propose that integration is the only solution to this situation. Isolated services for the indigent mentally ill will inevitably mean inferior or no care, and abuse. Only insurance coverage , and at least some federal supervision, will achieve genuine and quality care and protection for the indigent mentally ill person. The willingness of every state in the union (I am estimating, but am appalled that I am almost certainly correct) to relegate their indigent mentally ill citizens to the most inhumane conditions is, again, absolutely appalling.

I have presented needs more than solutions to them. I prefer as much be resolved on a local level as possible, but it appears to me that medical care is a national responsibility, both financially and in the area of providing for the preparation of an adequate number and quality of physicians to meet the medical needs of the national citizenry, with reasonable accessibility and costs to the citizenry.

There is also a serious need for the national supervision of the performance of physicians, as to the quality and the ethics of their services and fees, and as to a balance to the power within the medical community to shield themselves from accountability when they harm patients, either negligently or maliciously. Physicians should not be permitted to "move on to greener pastures" after they have been found incompetent in one community, and any criminal activity, especially medically related criminal activity, should result in the loss of licensure. These latter safeguards are important for the assurance of the availability and affordability of quality health care, and for the security of patients.

I am very pleased and encouraged that the Senate Finance Subcommittee is attending to the issue of a lack of adequate health care for so many Americans. Healthy Americans are essential to any other progress we might hope to make. I also much appreciate your attention to my concerns about health care.

Sincerely yours,

Sally Maria Baker

Sally Marie Baker
19169 Whitcomb
Detroit, MI 48235

JUNE 24, 1989

Dear Mr. Riegle, Jr.

I was not able to attend the hearing on 6/28 due to work scheduling but am very concerned about the cost of health care. I hve Blue Cross thru a group policy at work. It is a very basic hospitalization program and as of the middle of June it will cost me as much for the policy as I have taken out in Federal taxes each pay period. I cannot get an individual policy because of a pre-existing minor heart condition. I agree something has got to be done about health carelin America. I am praying for you and this situation. If Ican be of any help please let me know.

Thank You

Miss Rhonda Baker
8492 Lozier
Warren, Mi. 48089

Dear Sir: 6-27-89-

I would like to submit my written testimony concerning issues regarding health care.

I have been disabled for 14½ yrs - I have never received over $400 a month from SSI & I am on Medicaid. It is very hard to find doctors who will accept Medicaid, so many times I have gone without medical attention, emergency treatment & prescription drugs because Medicaid wouldn't cover it & I didn't have the money to pay for it.

In 1983 I was involved in accident in Canada, I asked to be taken back to Mich because of Medicaid - they wouldn't do it & I had to pay for the ambulance,

X-rays, stitches, tetanus shot, & emergency room expenses. Also, my wheelchair was totaled & the frame was bent, but Medicaid refused to help until April of 1984 - & I have to depend on my chair on a daily basis.

If this great nation of ours refus. to pay for our doctors, emergency medical treatment & medical equipmen why did they chose to keep so many of us alive at the onset of our disabilities!

Mary Lou Baranski

Our Health Care Needs - Barnes Family

form
Dated,
Example 1 1-28-88 Physician checked for strep throat.
Rheumatic fever can be the effects and possible heart
damage if not treated.
Is highly contagious the cost per person per.
family per year is multiplied by number in family.
If a family has no coverage, the effects are for a
(The deductible $25.00 + medicine per person per family)
lifetime. If not treated.
My father, had rheumatic fever during the depression years.
He was from a farm family with no insurance and
was not taken to a doctor because they could not
afford the medical bills. He was not accepted in the service.
He could not get certain jobs because of a weakened enlarged heart.
Today, Many parents with insurance send their
kids to school with illness because their
insurance will pay for all the penicillin and doctor bills.
Then those families' children without full coverage
or no insurance suffer paying for it out of their own pocket expenses.
This applys to children who have ear aches
and also need medicine. They may go without medicine and
have hearing problems because they didn't get the penicillin
they need to clear up the infection.

My father was a farmer, he attended 1yr at MSU for
(Carl D Mitchell)
Agriculture received a certificate to be a herdsmen or dairy farmer on the farm.
He sold the farm because he couldn't make it economically and as a
During his lifetime he worked in a trailer factory
VA Battle Creek Hospital, Psychiatric Nurses Asst. for 20-25 yrs
and at the BC Sanitarium Hospital. Raised four children.
He is now retired. Inspite of heart damage from
rhematic fever, he worked two job throughout his life.
He took care of (veterans) some are psychiatric patients, alcoholics, and drug
addicts. This is a very demanding and stressful job.
He works with patients more than doctors or is in their company more.
He may have had a stroke because a patient
knocked him unconsious at work, on the job, when
a VA doctor didnot prescribe a tranquilizer to a violent
patient he was in charge of. A blood clot may have caused it
or contributed to the the heart attack (over)

My Dad has had a quadruple bypass surgery.
He was not 65 then Could not receive
medicare to help pay bills and medicines.

Do you think its fair, ~~that~~ for someone
who ~~takes~~ took care of veteran drug addicts alcoholics and
psychiatric patients and later cannot pay for his medical bills
without loosing his home or life savings?

The Mail Handlers
Benefit Plan

P.O. Box 6222
Rockville, MD 20850
(301) 738-1260

SS # 363-44-3293
ENROLLEE: THOMAS BARNES
PATIENT: MICHAEL BARNES CH

04/15/88

THOMAS BARNES
12770 COMMONWEALTH
SOUTHGATE MI 48195

DEAR THOMAS BARNES :

WE HAVE COMPLETED OUR REVIEW OF THE FOLLOWING CLAIM:

PROVIDER	DATE	CHARGE
CHILD & ADOLESCENT CENTER PC	01/28/88	25.00

A REVIEW OF THE PATIENT'S RECORDS INDICATES THAT THE ABOVE CHARGE IS FOR THE FIRST DOCTOR'S VISIT IN THE CALENDAR YEAR FOR THE ABOVE NAMED PATIENT. ACCORDING TO THE PROVISIONS OF THE MAIL HANDLERS BENEFIT PLAN EFFECTIVE JANUARY 1, 1988, BENEFITS FOR OUTPATIENT DOCTORS' VISITS FOR A MEDICAL ILLNESS, MENTAL DIAGNOSIS, OR SUBSTANCE ABUSE CONDITION ARE PROVIDED BEGINNING WITH THE SECOND VISIT PER CALENDAR YEAR. THEREFORE, WE ARE UNABLE TO PROVIDE BENEFITS FOR THE ABOVE EXPENSES UNDER THE TERMS OF YOUR COVERAGE. PLEASE REFER TO THE "OTHER MEDICAL BENEFITS" SECTION OF YOUR PLAN BROCHURE.

IF YOU DISAGREE WITH OUR DECISION, YOU MAY REQUEST A RECONSIDERATION BY WRITING TO OUR CUSTOMER SERVICE DEPARTMENT WITHIN ONE YEAR OF THE DATE OF THIS LETTER. YOUR REQUEST SHOULD STATE, IN TERMS OF THE APPLICABLE BROCHURE PROVISIONS, THE REASONS YOU BELIEVE THE CLAIM SHOULD BE PAID. PLEASE INCLUDE A COPY OF THIS LETTER AND ANY ADDITIONAL INFORMATION WHICH MAY SUPPORT YOUR POSITION. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT AT THE NUMBER ABOVE, AND A REPRESENTATIVE WILL BE HAPPY TO ASSIST YOU.

SINCERELY,

CLAIMS DEPARTMENT

Pharangytis tosee ~~if~~ Child has
Tonsilitis or Strept Throat

CHILD & ADOLESCENT CTR PC, D.K. LI,MD,PC
15350 TRENTON ROAD
SOUTHGATE, MI 48195
(313)-283-4616

Acct: THOMAS H. BARNES
12794 COMMONWEALTH
#31 SOUTHGATE, MI 48195

Date: 01/28/88

Patient	Description of Service	Total Amt	Patient Amt	Insurance Amt
	** Previous Balance:	[illegible]	[illegible]	0.00
MICHAEL	OFFICE VIS ILL CHILD	25.00	25.00	0.00
MICHAEL	THROAT CULTURE	15.00	15.00	0.00
	CASH PAYMENT	-20.00	-20.00	0.00

	Total Amt	Patient Amt	Insurance Amt
Total Charges:	40.00	40.00	0.00
Total Payments:	-20.00	-20.00	0.00
New Balance:	20.00	20.00	0.00

Throat

PATIENT NAME Barnes Mike (Tom) DATE OF SERVICE 01-28-88
(LAST) (FIRST)

PLACE OF SERVICE: DOCTOR'S OFFICE BC HC IH MA MM PP SC PC [✓ OT] PCY

KEY-IN	SERVICE	CODE	KEY-IN	SERVICE	CODE	KEY-IN	SERVICE	CODE	KEY-IN	SERVICE	CODE
EXT	Ext. Visit/MA	90080	NASAL	Nasal Culture	89190	ALL	Allergy Inj.	95125	SPI	Spinal Tap	62270
IOV	Initial Visit	90020	NS	Nasal Smear	89190	CR	C.R. Bicillin 600,000u	J0530	RS	Suture Removal	T7010
IOVMA	Initial Visit/MA	90050	PLT	Platelet Count	85580	CR9	C.R. Bicillin 900,000u	J0540	SUT1	Suturing (Scalp, neck,	
ME	Medical Emer.	99058	SED	Sed Rate	85650	LA12	L.A. Bic. 1.2 mil	J0570		axillae, ext. genitalia,	
OV	Office Visit	90060	THE	Theophyllin Bld Level	84420	LA6	L.A. Bic. 600,000u	J0560		trunk, extremeties)	12001
30V	[✓ Office Visit/III]	90060	TC	[✓ Throat Culture]	87060	PRE	Prednisone Inj.	J2640	SU2	Suturing (face, ear,	
20V	OV/JHSC 0-2 yr	90060	U	Urinalysis	81000	SUS	Susphrine Inj	J0170		eyelids, nose, lips,	
30V	OV/JHSC 3-19	90060	SU	Urinalysis Sick	81000	VIST	Vistaril	J3410		mucous membranes)	12011
RECH	Recheck/Brief	90050	UC	Urine Culturia	87086	BDL	Burn Drsg. Large	16030	UMB	Umbilical Cautery	36510
MRECH	Recheck/MA	90050	WBC	White Blood Count	85048	BDM	Burn Drsg. Mod.	16025	AC	Allergy Consult	90620
AUD	Audio Screen	92551	IMM	Immunoglobulin	86329	BDS	Burn Drsg. Small	16020	AV	Allergy Vaccine	95155
TYM	Tympanogram	92567	PPD	Tuberculin Test	86585	BUR	Burn init No Drsg.	16000	NEB	Nebulization	94640
EYES	Vision Test	92499	DPT	Dipth. Pert. Tet.	90701	CAUT	Cauterize/Wart Tx.	17110	SPB	Spirometry Bronchodilator	94060
BIL	Bilirubin	80002	DT	Dipth. Tet.	90701	AID	First Aid	X0050	SPI	Spirometry/graphic rec.	94010
C.B.C.	C.B.C.	85022	HIB	H-influenzae Vacc.	90737	FBE	Foreign Rem. Ear	69200	AT	Allergy Testing	95001
GTT	Glucose Tolerance Test (3)	82951	MMR	Meas. Mumps Rub.	90707	FBI	F. Body Rem. Eye	65205	IT	Intradermal (11-15) Testing	95017
GLU	Glucose Test	80002	MPS	Mumps Vaccine	J6035	FBN	F.B. Rem. Nose	30300	PEAK	Peak Flow Rate	94160
GUI	Guiac Test	82270	MR	Meas. Rub. Vacc.	90707	FBS	F.B. Rem. Skin	10120			
HGB	Hemoglobin/Blood	85018	OPV	Oral Polio Vacc.	90712	ID	Incision & Drain.	10060			
MONO	Mono Test	86300	ADR	Adrenalin Inj.	J0170	DIS	Reduct. Dislocat.	24640			

KEY-IN	DIAGNOSIS	CODE	KEY-IN	DIAGNOSIS	CODE	KEY-IN	DIAGNOSIS	CODE	KEY-IN	DIAGNOSIS	CODE
ABD	Abdominal Pain	7890	DEH	Dehydration	2765	HYG	Hypoglycemia	2512	ROS	Roseola	0569
HYP	ADD	3149	DRH	Diaper Rash	6910	IBS	Irritable Bowel Syndrome	5641	SCA	Scabies	1330
ALR	Allergic Reaction	9953	DE	Dislocation, Elbow	83200	IMP	Impetigo	684	SCF	Scarlet Fever	0341
RHA	Allergic Rhinitis	4779	EAR	Earache	3887	TOE	Ingrown Toe Nail	7030	SEB	Seborrhea	7063
ANE	Anemia	2859	ECZ	Eczema	6918	INS	Insect Bites	9895	SIN	Sinusitis	4739
ANF	Annal Fissure	5650	ENU	Enuresis	3076		Injury________		ST	Strep Throat	0340
AEC	Annual Exam	V705	EPI	Epistaxis	7847	LAG	Laryngitis	4640	TOM	Stomatitis	5280
APP	Appendicitis	5400	EUS	Eustachean Tube Dysf.	38181	LT	Laryngotracheitis	46420	SUT	Removal of Sutures	9789
ART	Arthritis	7169	EXP	Exposure to Strep	V019	LIC	Lice, Head	1329	SYN	Syncope	7802
AST	Asthma/Asth. Bronch.	4930	FAIL	Failure to Thrive	7834	LYD	[✓ Lymphadenitis]	2893	SYS	Synovitis	7192
BRO	Bronchitis	4660		F.B. Removed________		MEN	Meningitis	3229	TDB	Tear Duct Blockage	37556
BLR	Bronchiolitis	4661	5	Fifth Disease	0570	MEN	Mesenteric Adenitis	2892	THR	Thrush	1120
BROS	Bronchospasm	5191	FLU	Influenza	4871	MA	Metatarsus Adductus	7545	TIB	Tibial Torson	73689
	Burn________		FPI	Feeding Problem-Infant	7833	MONO	Infectious Mononucleosis	075	TON	[✓ Tonsilitis]	463
CELL	Cellulitis	6829	FUO	Fever	7806	MYO	Myositis	7291	TRA	Tracheitis	46410
POX	Chicken Pox	0529	G	Acute Gastritis	5250	NPH	Nasopharyngitis	460	UMB	Umbilical Granuloma	6861
CHP	Chest Pain	78650	GE	Gastreoenteritis	0088	OB	Obesity	2780	URI	Upper Resp. Inf.	4650
COD	Convulsive Disorder	3451	HEAD	Headaches	7840	OTE	Otitis Externa	38010	URT	Urticaria	7080
CD	Contact Dermatitis	6920	HI	Head Injury	8540	OM	Otitis Media	3820	UTI	Urinary Tract Infection	5990
COF	Cough	7862	HM	Heart Murmur	7852	OS	Otitis Serous	3814	VAG	Vaginitis	61610
COL	Colic	7890	HEM	Hematuria	5997	PET	Petechiae	7726	VIR	Viral Syndrome	0799
CONC	Cerebral Concussion		HEP	Hepatitis	5733	PHAR	[✓ Pharyngitis]	462	WART	Wart(s)	0781
CONJ	Conjunctivitis	3720	HR	Hernia	5539	PIV	Poison Ivy, Oak or Sumac	6926	WELL	Well Baby	V202
COS	Constipation	5640	HSX	Herpes Simplex	0540	PNE	Pneumonia	4870		________Misc	
CRP	Croup	4644	HZ	Herpes Zoster	0530	PYO	Pyoderma	686			
CYS	Cystitis	5950	JD	Hyperbilirubinemia	7824	RAS	Rash	7821			

RETURN: ________Days ________Weeks ________Months

Next Appointment________________ AM PM

Height________ Weight________

Instructions

CHILD & ADOLESCENT CENTER, P.C.
Tax ID #38-2057833
15350 Trenton Road, Southgate, MI 48195
Telephone (313) 283-4616
Blue Cross ID #350H27736

*** WE'VE MOVED ***
NEW PHONE NUMBER
(301) 738-1260

Mail Handlers Benefit Plan
P.O. Box 6222
Rockville, MD 20850
([illegible])

The Mail Handlers Benefit Plan
[redacted]

PLEASE RETAIN FOR YOUR RECORDS. SEE REVERSE FOR EXPLANATION.

CLAIM NO. [illegible] CHECK NO. 17937804 DCN 88091421112 DATE 04/15/88

ENROLLEE	PATIENT
HOMAS BARNES 770 COMMONWEALTH OUTHGATE, MI 48195	NAME MICHAEL BARNES MHBP ID# 368-44-8193 PATIENT ACCT # MICHEAL BARNES REL CODE C1

LINE	CHARGE	REDUCED CHARGE	AMOUNT EXCLUDED	CODE	DEDUCTED AMOUNT	COVERED CHARGE	%	BENEFIT AMOUNT
1	25.00	25.00	25.00	DFR				
2	15.00	15.00				15.00	100	15.00
3								
4								
5								
6								
7								
8								
TOTAL	40.00	40.00	25.00			15.00		15.0

LINE	DATES OF SERVICE FROM TO	TYPE OF SERVICE DESCRIPTION	PROVIDER OF CARE
1	01/28/88-01/28/88	OFFICE/HOME VISITS	CHILD & ADOLESCEN
2	01/28/88-01/28/88	DIAG XRAY/LAB	CHILD & ADOLESCEN
3			
4			
5			
6			
7			
8			

REMARKS

DFR-BENEFITS BEGIN WITH SECOND OFFICE VISIT

Insurance Wont Pay this each year. per person in ~~per~~ family

COORDINATION OF BENEFITS EXPLANATION	
AMOUNT ELIGIBLE FOR COORDINATION	
MINUS AMOUNT PAID BY	
MHBP BENEFIT AMOUNT	15.
FROM CREDIT RESERVE	
TOTAL MHBP PAYMENT	15.

COST CONTAINMENT
ENROLLEE SAVINGS:

OUT-OF-POCKET
FAMILY: INDIVIDUAL:

Ex2

Enclosed is a copy of an estmate for
orthodontic treatment for my son, michael age 11.
My husband also needs orthodontics, but
never could afford it from a family of nine. He works for the VA R.O.-Detroit Office
Mail Handlers pays for no orthodontic
treatments; yet it pays for mental conditions, substance
abuse to a maximum of $1000 per person per
calendar year. It pays for no prescription eyeglasses
or eye exams. A deductible per person is required
per calendar year. Why is this? It is not my
son's or any one's fault they need glasses or
orthodontics. Edison, Auto Companies and teachers
have full or a portion paid of the fees charged
beside the office visit fees paid by their company or union.

We don't need this for our family

The insurance doesn't pay for medical or dental
that are the ordinary or usual illnesses, or for necessary
preventive medicine, regular checkups for dental or
medical.

Mail Handlers doesn't pay for what we need to have
done as preventive medicine. Most people may not
need to go to a doctor for years unless it is
for a checkup or dental cleaning and fillings. or eye exam.
Yet, when my son needs orthodontics the insurance pays
nothing.

Why do we pay for state funded abortions when we limit
our own family because of economic reasons and still
as a government employees family we cannot afford
orthodontics, glasses, or yearly checkup for our small family of four
in total of 2 children & 2 adults?

A Gov employee recieved a 2% pay raise in last 10 yrs

Ex2

DRS. CLAUSS, HEISEL & KUTT, P. C.
Orthodontics

William J. Clauss, D.D.S., M.S.
William A. Heisel, D.D.S., M.S.
J. Daniel Kutt, D.D.S., M.S.

1605 Fort Street
Wyandotte, Michigan 48192
AV 2-4100

January 12, 1989

To Whom It May Concern:

Re: Michael T. Barnes

Michael presented with crowding of the dental arches which requires orthodontic treatment.

The fee for orthodontic treatment and retention is $2400.00 over a period of approximately two years.

Sincerely,

William A. Heisel

WAH/jd

Ex 4

Besides the dental deductibles per person
there are the medical deductibles per Calendar year.
per person ina family
People will not be taking preventive measures
by getting regular checkups and x-rays.

* OFTEN this insurance refuses to pay without
Writing letters in disagreement of their decision.
OFTEN The doctor or dentist already submitted
to the insurance a statment or bill showing
treatments as standard., necessary, emergency or
a diagnostic test. or x-ray given to all patients.
regardless of insurance-
The insurance Co. should get this information from
the physician or doctor, I had not been for an x-ray-
mammyogram or pap smear test for 10 years yet they called
the mammogram unnecessary and were not going to pay for it.

Our family deductibles per person for annual physical exam
would be $100 whether you are ill or well for a family of
four.

Besides paying the dental deductibles per person
per family for dental. We are paying the bi-weekly
$28.30 Health insurance enrollment code deduction or $735.80 per year
* but it doesn't pay for what we need for family care
especially of young preeschool and schoolage children
who have more strep throat and ear infections office visits
and need immunizations and booster shots. or special
ortho pedic shoes. They also need regular eye exams.

The Mail Handlers
Benefit Plan
[redacted]
P.O. Box 6222
Rockville, MD 20850
(301) 738-1260

SS # [illegible]
ENROLLEE: THOMAS BARNES
PATIENT: SHARON BARNES SP

04/19/88

THOMAS BARNES
12770 COMMONWEALTH
SOUTHGATE MI 48195

DEAR THOMAS BARNES :

WE HAVE COMPLETED OUR REVIEW OF THE FOLLOWING CLAIM:

PROVIDER	DATE	CHARGE
PROVIDER OF CARE	01/22/88	20.00

A REVIEW OF THE PATIENT'S RECORDS INDICATES THAT THE ABOVE CHARGE IS FOR THE FIRST DOCTOR'S VISIT IN THE CALENDAR YEAR FOR THE ABOVE NAMED PATIENT. ACCORDING TO THE PROVISIONS OF THE MAIL HANDLERS BENEFIT PLAN EFFECTIVE JANUARY 1, 1988, BENEFITS FOR OUTPATIENT DOCTORS' VISITS FOR A MEDICAL ILLNESS, MENTAL DIAGNOSIS, OR SUBSTANCE ABUSE CONDITION ARE PROVIDED BEGINNING WITH THE SECOND VISIT PER CALENDAR YEAR. THEREFORE, WE ARE UNABLE TO PROVIDE BENEFITS FOR THE ABOVE EXPENSES UNDER THE TERMS OF YOUR COVERAGE. PLEASE REFER TO THE "OTHER MEDICAL BENEFITS" SECTION OF YOUR PLAN BROCHURE.

IF YOU DISAGREE WITH OUR DECISION, YOU MAY REQUEST A RECONSIDERATION BY WRITING TO OUR CUSTOMER SERVICE DEPARTMENT WITHIN ONE YEAR OF THE DATE OF THIS LETTER. YOUR REQUEST SHOULD STATE, IN TERMS OF THE APPLICABLE BROCHURE PROVISIONS, THE REASONS YOU BELIEVE THE CLAIM SHOULD BE PAID. PLEASE INCLUDE A COPY OF THIS LETTER AND ANY ADDITIONAL INFORMATION WHICH MAY SUPPORT YOUR POSITION. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT AT THE NUMBER ABOVE, AND A REPRESENTATIVE WILL BE HAPPY TO ASSIST YOU.

SINCERELY,

CLAIMS DEPARTMENT

DF / 123 /000000000000000 DCN: 88096331906 CLAIM: 331906000

(Mail handlers Insurance) I had not been to a doctor for ten years because of the yearly yearly person plan.

They deductible per or even every 10 years (deductible $20-25)

Refuse to pay a yearly a physical exam — or X-rays or mammograms without writing letters and disagreeing with their decisions. When the doctors already had submitted to insurance as a standard treatment as necessary or emergency diagnostic testing & treatment.

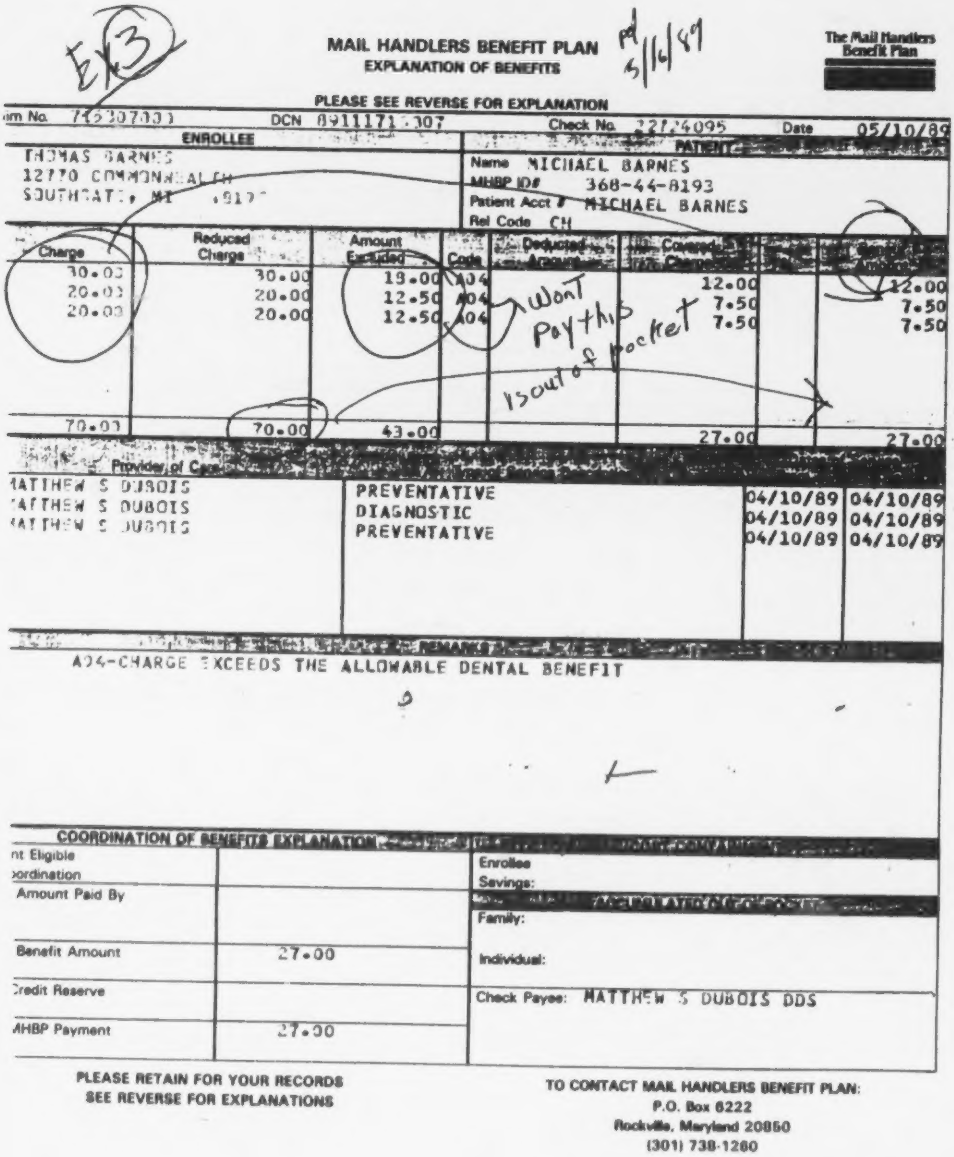
or emergency treatment

Ex3

Enclosed are dental charges for preventive
and diagnostic care. They exceed the allowable
dental benefit; more than half what the insurance will pay.

Sincerely,

Sharon T. Barnes



Ex3

MAIL HANDLERS BENEFIT PLAN
EXPLANATION OF BENEFITS

pd 5/16/89

The Mail Handlers Benefit Plan

PLEASE SEE REVERSE FOR EXPLANATION

im No. 7[illegible]307000 DCN 8911171[illegible]307 Check No. [illegible]2724095 Date 05/10/89

ENROLLEE	PATIENT
THOMAS BARNES 12770 COMMONWEALTH SOUTHGATE, MI [illegible]	Name MICHAEL BARNES MHBP ID# 368-44-8193 Patient Acct # MICHAEL BARNES Rel Code CH

Charge	Reduced Charge	Amount Excluded	Code	Deducted Amount	Covered Charge	[illegible]	Benefit Amount
30.00	30.00	18.00	A04		12.00		12.00
20.00	20.00	12.50	A04		7.50		7.50
20.00	20.00	12.50	A04		7.50		7.50
70.00	70.00	43.00			27.00		27.00

Wont pay this
is out of pocket

Provider of Care			
ATTHEW S DUBOIS	PREVENTATIVE	04/10/89	04/10/89
ATTHEW S DUBOIS	DIAGNOSTIC	04/10/89	04/10/89
ATTHEW S DUBOIS	PREVENTATIVE	04/10/89	04/10/89

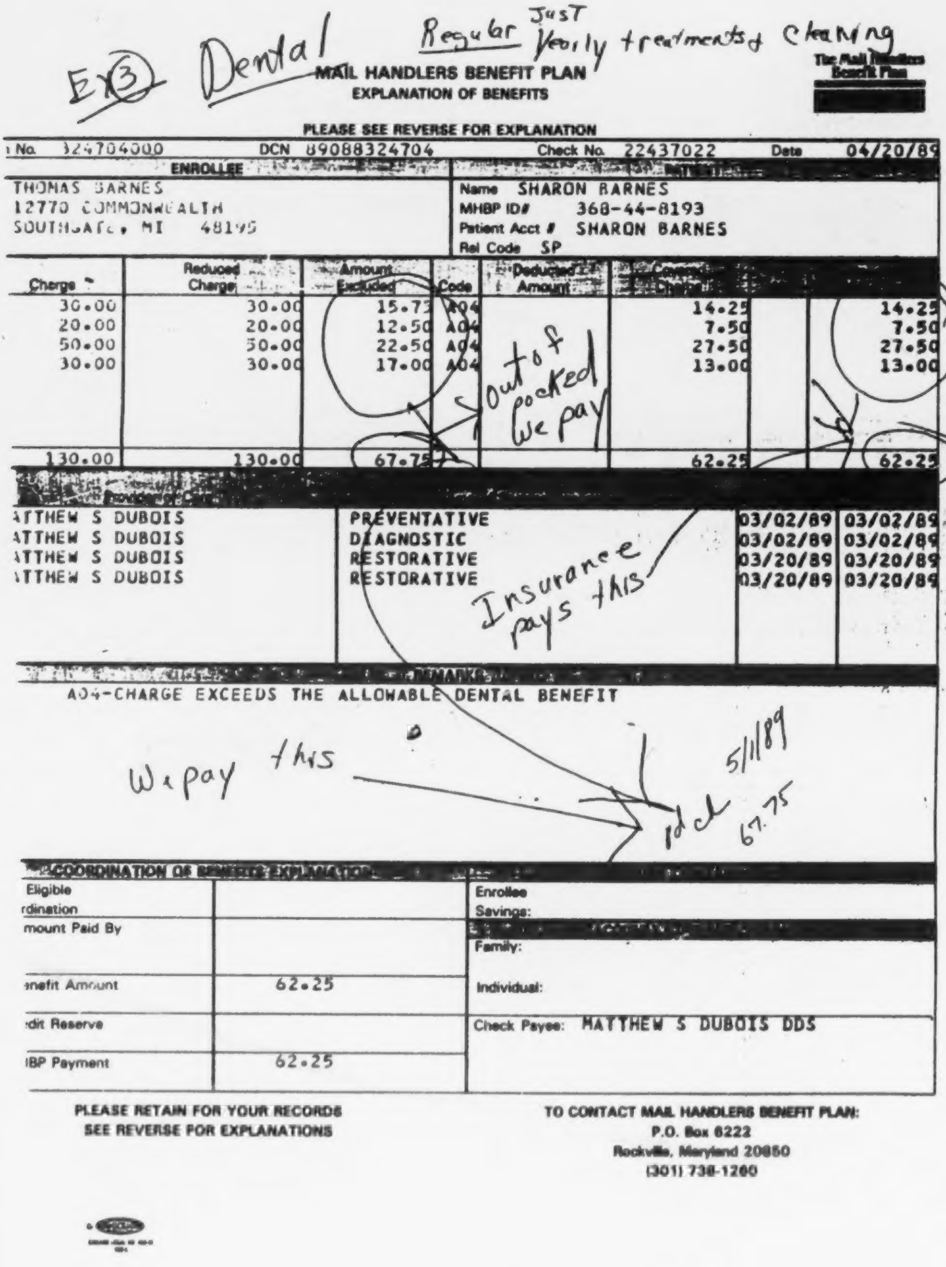
REMARKS

A04-CHARGE EXCEEDS THE ALLOWABLE DENTAL BENEFIT

COORDINATION OF BENEFITS EXPLANATION		
nt Eligible ordination		Enrollee Savings:
Amount Paid By		ACCUMULATED OUT-OF-POCKET Family:
Benefit Amount	27.00	Individual:
redit Reserve		Check Payee: MATTHEW S DUBOIS DDS
MHBP Payment	27.00	

PLEASE RETAIN FOR YOUR RECORDS
SEE REVERSE FOR EXPLANATIONS

TO CONTACT MAIL HANDLERS BENEFIT PLAN:
P.O. Box 6222
Rockville, Maryland 20850
(301) 738-1260



Ex③ Dental Regular Just Yearly treatments & Cleaning

MAIL HANDLERS BENEFIT PLAN
EXPLANATION OF BENEFITS

The Mail Handlers Benefit Plan

PLEASE SEE REVERSE FOR EXPLANATION

No. 324704000 DCN 89088324704 Check No. 22437022 Date 04/20/89

ENROLLEE	[illegible]
THOMAS BARNES 12770 COMMONWEALTH SOUTHGATE, MI 48195	Name SHARON BARNES MHBP ID# 368-44-8193 Patient Acct # SHARON BARNES Rel Code SP

Charge	Reduced Charge	Amount Excluded	Code	Deducted Amount	Covered Charge	[illegible]	[illegible]
30.00	30.00	15.75	A04		14.25		14.25
20.00	20.00	12.50	A04		7.50		7.50
50.00	50.00	22.50	A04		27.50		27.50
30.00	30.00	17.00	A04		13.00		13.00
130.00	130.00	67.75			62.25		62.25

out of pocked we pay

Provider of Service	[illegible]	[illegible]	[illegible]
ATTHEW S DUBOIS	PREVENTATIVE	03/02/89	03/02/89
ATTHEW S DUBOIS	DIAGNOSTIC	03/02/89	03/02/89
ATTHEW S DUBOIS	RESTORATIVE	03/20/89	03/20/89
ATTHEW S DUBOIS	RESTORATIVE	03/20/89	03/20/89

Insurance pays this

REMARKS

A04-CHARGE EXCEEDS THE ALLOWABLE DENTAL BENEFIT

We pay this

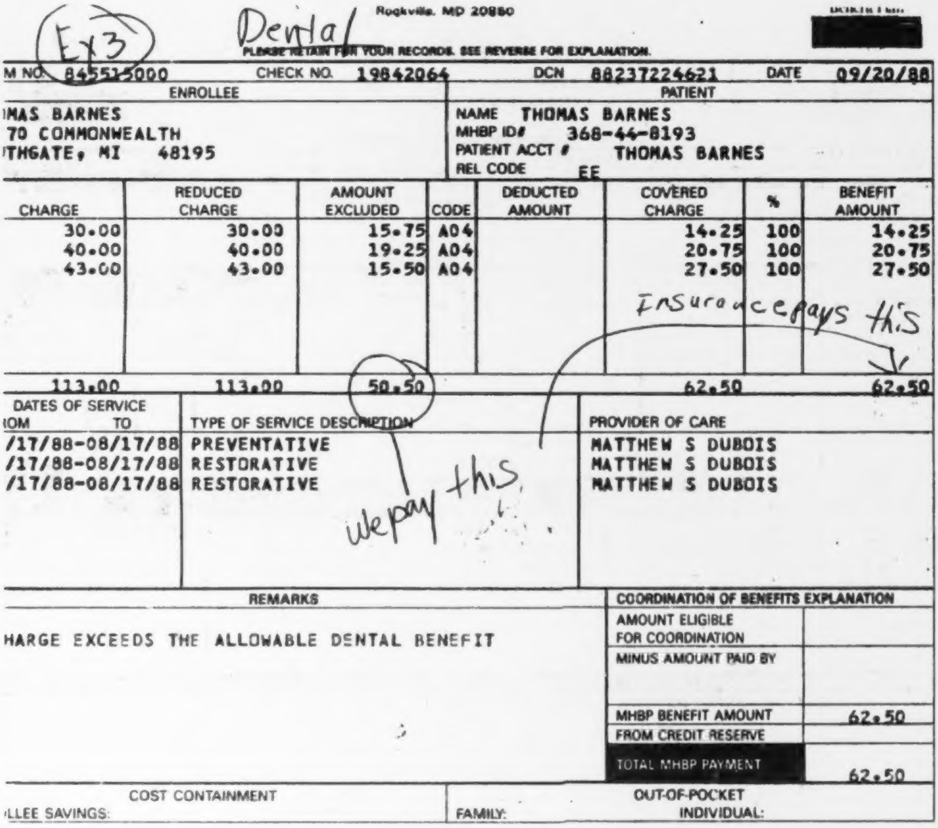
pd ck 5/1/89 67.75

COORDINATION OF BENEFITS EXPLANATION

Eligible rdination		Enrollee Savings:
mount Paid By		Family:
enefit Amount	62.25	Individual:
dit Reserve		Check Payee: MATTHEW S DUBOIS DDS
IBP Payment	62.25	

PLEASE RETAIN FOR YOUR RECORDS
SEE REVERSE FOR EXPLANATIONS

TO CONTACT MAIL HANDLERS BENEFIT PLAN:
P.O. Box 6222
Rockville, Maryland 20850
(301) 738-1260



Ex3

Dental

Rockville, MD 20850

[redacted]

PLEASE RETAIN FOR YOUR RECORDS. SEE REVERSE FOR EXPLANATION.

M NO. 845515000 CHECK NO. 19842064 DCN 88237224621 DATE 09/20/88

ENROLLEE	PATIENT
MAS BARNES 70 COMMONWEALTH THGATE, MI 48195	NAME THOMAS BARNES MHBP ID# 368-44-8193 PATIENT ACCT # THOMAS BARNES REL CODE EE

CHARGE	REDUCED CHARGE	AMOUNT EXCLUDED	CODE	DEDUCTED AMOUNT	COVERED CHARGE	%	BENEFIT AMOUNT
30.00	30.00	15.75	A04		14.25	100	14.25
40.00	40.00	19.25	A04		20.75	100	20.75
43.00	43.00	15.50	A04		27.50	100	27.50
113.00	113.00	50.50			62.50		62.50

Insurance pays this

we pay this

DATES OF SERVICE ROM TO	TYPE OF SERVICE DESCRIPTION	PROVIDER OF CARE
/17/88-08/17/88	PREVENTATIVE	MATTHEW S DUBOIS
/17/88-08/17/88	RESTORATIVE	MATTHEW S DUBOIS
/17/88-08/17/88	RESTORATIVE	MATTHEW S DUBOIS

REMARKS

HARGE EXCEEDS THE ALLOWABLE DENTAL BENEFIT

COORDINATION OF BENEFITS EXPLANATION	
AMOUNT ELIGIBLE FOR COORDINATION	
MINUS AMOUNT PAID BY	
MHBP BENEFIT AMOUNT	62.50
FROM CREDIT RESERVE	
TOTAL MHBP PAYMENT	62.50

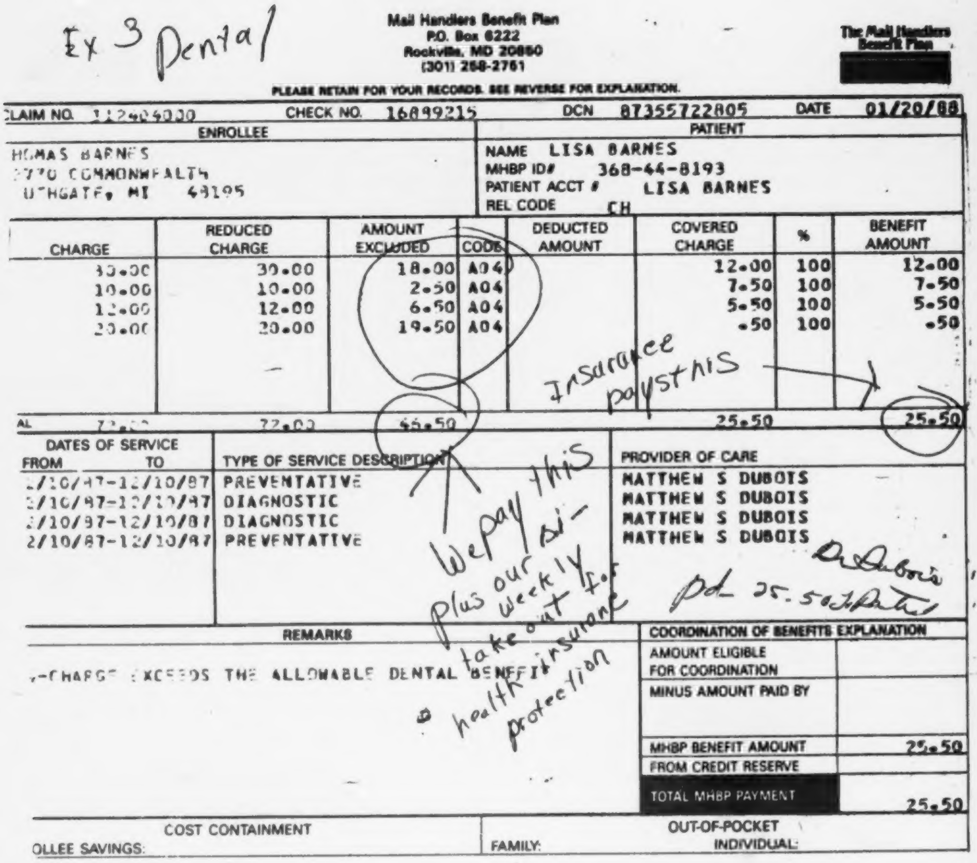
COST CONTAINMENT

LLEE SAVINGS:

OUT-OF-POCKET

FAMILY:

INDIVIDUAL:



Ex 3 Dental

Mail Handlers Benefit Plan
P.O. Box 6222
Rockville, MD 20850
(301) 258-2761

The Mail Handlers Benefit Plan

PLEASE RETAIN FOR YOUR RECORDS. SEE REVERSE FOR EXPLANATION.

LAIM NO. 112404030 CHECK NO. 16899215 DCN 87355722805 DATE 01/20/88

ENROLLEE	PATIENT
HOMAS BARNES 770 COMMONWEALTH UTHGATE, MI 48195	NAME LISA BARNES MHBP ID# 368-44-8193 PATIENT ACCT # LISA BARNES REL CODE CH

CHARGE	REDUCED CHARGE	AMOUNT EXCLUDED	CODE	DEDUCTED AMOUNT	COVERED CHARGE	%	BENEFIT AMOUNT
30.00	30.00	18.00	A04		12.00	100	12.00
10.00	10.00	2.50	A04		7.50	100	7.50
12.00	12.00	6.50	A04		5.50	100	5.50
20.00	20.00	19.50	A04		.50	100	.50
AL 72.00	72.00	46.50			25.50		25.50

Insurance pays this

DATES OF SERVICE FROM TO	TYPE OF SERVICE DESCRIPTION	PROVIDER OF CARE
2/10/87-12/10/87	PREVENTATIVE	MATTHEW S DUBOIS
2/10/87-12/10/87	DIAGNOSTIC	MATTHEW S DUBOIS
2/10/87-12/10/87	DIAGNOSTIC	MATTHEW S DUBOIS
2/10/87-12/10/87	PREVENTATIVE	MATTHEW S DUBOIS

We pay this plus our bi-weekly take out for health insurance protection

Dr Dubois pd 25.50 to Patient

REMARKS

-CHARGE EXCEEDS THE ALLOWABLE DENTAL BENEFIT

COORDINATION OF BENEFITS EXPLANATION

AMOUNT ELIGIBLE FOR COORDINATION	
MINUS AMOUNT PAID BY	
MHBP BENEFIT AMOUNT	25.50
FROM CREDIT RESERVE	
TOTAL MHBP PAYMENT	25.50

COST CONTAINMENT
OLLEE SAVINGS:

OUT-OF-POCKET
FAMILY:
INDIVIDUAL:

Ex3 Dental

Mail Handlers Benefit Plan
P.O. Box 6222
Rockville, MD 20850

The Mail Handlers Benefit Plan

PLEASE RETAIN FOR YOUR RECORDS. SEE REVERSE FOR EXPLANATION.

D. [illegible] CHECK NO. 13443475 DCN [illegible] DATE 08/17/88

ENROLLEE	PATIENT
BARNES COMMONWEALTH ATH, MI 48[illegible]	NAME THOMAS BARNES MHBP ID# 362-44-3193 PATIENT ACCT # THOMAS BARNES REL CODE [illegible]

ARGE	REDUCED CHARGE	AMOUNT EXCLUDED	CODE	DEDUCTED AMOUNT	COVERED CHARGE	%	BENEFIT AMOUNT
135.00	135.00	122.00	404		13.00	100	13.00
10.00	10.00	2.50	404		7.50	100	7.50
50.00	50.00	28.00	404		22.00	100	22.00
195.00	195.00	152.50			42.50		42.50

ES OF SERVICE TO	TYPE OF SERVICE DESCRIPTION	PROVIDER OF CARE
/88-07/14/88	PERIODONTICS	MATTHEW S DUBOIS
/88-07/14/88	DIAGNOSTIC	MATTHEW S DUBOIS
/88-07/14/88	DIAGNOSTIC	MATTHEW S DUBOIS

We paid

Insurance pays only This

REMARKS

SE EXCEEDS THE ALLOWABLE DENTAL BENEFIT

COORDINATION OF BENEFITS EXPLANATION	
AMOUNT ELIGIBLE FOR COORDINATION	
MINUS AMOUNT PAID BY	
MHBP BENEFIT AMOUNT	42.50
FROM CREDIT RESERVE	
TOTAL MHBP PAYMENT	42.50

COST CONTAINMENT SAVINGS:

OUT-OF-POCKET FAMILY: INDIVIDUAL:

July 14, 1989

Century Center Building
30800 Van Dyke Avenue
Warren , Michigan
48093

Attn. Senator Donald W. Riegle

Re. Health Care for the Uninsured

Sir;

We were unable to attend the hearing by The Senate Finance Subcommittee on June 28th, but felt your concern and helpfulness in trying to right this wrong is an extremely worthwhile endeavor.

As an example of the seriousness of the situation, we detail our particular experience as follows:

My wife Kathleen has had three heart attacks, and has been covered under Blue Cross for each incident until January 1st, 1989, at which time because of the cost as a small subscriber, we were unable to make one payment on time.

We made every effort to get our payment to Blue Cross, albeit it was late, and continued back on schedule after this one incident. Much to our surprise, after we had continued to make on time payments for three months, Blue Cross sent us a check for the full amount of our premiums from the 1st of January, and notified us we were cancelled.

Upon re-applying, they informed us of the new rules of the game, which specifically limits the conditions they will accept "New Members", and also stated that any pre-existing conditions (Kathleen's heart problem) is conveniently excluded.

We have worked through our insurance agent who has tried dozens of companies, and find that this stipulation is prevalent throughout the insurance industry.

We are now faced with one alternative to apply for Social Security Disability Insurance, which from all indications takes 2-3 years for approval. In the meantime, we are at the mercy of the doctors and hospitals who demand, and will almost not accept anyone who cannot produce some type of health card, plus this also aggravates Kathleen's condition, because in the event she would need major medical care, we could conceivably lose all we have worked for in one hospital stay.

"Thank You" for your time to go over our letter, and hope with all our hearts, you can come up with some form of nationwide health care insurance in the very near future to forestall the worst case scenario we have described above, we are sure this is one of the lessor cases you have heard about, but to us it is a major catastrophic problem.

We hate to ask, but if there is any way you or your office knows of to get Kathleen on the Social Security Disability Program quicker it would be most helpful.

Keep up the good work, and wish you luck in this endeavor.

Cordially

Leonard & Kathleen Batchelder
21111-22 Mile Road
Mount Clemens, Michigan
48044

Blind

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: Evelyn Becker

Address 526 E. Drayton
Ferdale, 48220

Representing : her self...

****

I invite you to attach a prepared statement or to submit your written testimony:

I am Blind; I am Caught between two programs and have to wait for two years for Medicare coverage. My prescription drugs total over $200 a month, not including Doctors Bills. My income is to high for S. services. These bills have forced me to give up my phone to pay for food.

Some community groups have provided one time only assistance.

You have to do something to help people like myself who are caught in this situation. Evelyn G. Becker

Dear Senator Riegle,

Thank you for accepting my testimony today, I will try to be as brief as possible

I am 29 yrs. old and recently finished almost 7 weeks in the hospital due to a brain abcess which contributed to the first siezure I ever encountered in my life. I am uninsured.

I applied for Medicaid twice only to be turned down each time, reasons cited, "not disabled by Medicaid standards" and "estimated duration of impairment is insufficient". That decision left me with two options to pay the 52,557 dollar hospital bill, according to the "patient representative", pay the bill back at a rate of 400 dollars a week for two years, (the hospital will not lengthen payment plans longer than two years) or sign a contract for the county to assume payment. If the bill is not paid for at the event of my death the county is awarded my house - what a deal. However this contractual arrangement does not include out-patient bills, which are currently 737 dollars and mounting. Monthly my blood must be checked to monitor liver damage caused by anti-siezure medication and more expensive cat-scans are in my future. Yet, if I were an un-wed mother or a drug addict Medicaid would take care of everything!

Unfortunately, the tale does not end here. In order to support myself I need to drive, but I have to be siezure free for six months. This makes no difference to both the finance and auto insurance companies, as they demand full coverage on my Ranger parked in the garage for the last three months.

I have been working since I was 13 and I am offended by a system which I have supported and have never asked for anything before. I find myself in fear of my situation, in fear for my generation, and for generations yet to come.

Well at least we have enough missles and rich defense contractors.

Thank You,

Mark Bishop

June 30, 1989

Senator Donald Reigle
700 Washington Square Bldg.
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Reigle,

I received your letter on 6/27/89 and regret I cannot be there in person. However, I have noticed the following gaps in our health care system.

Employers who employ individuals part-time have no obligation to provide health insurance. Many companies are keeping people on part-time employment just to avoid the payment of health insurance. It is even a common practice to promise health insurance to full-time employees, but never provide the employees the policies. It is also a common practice of employers to constantly change insurance to avoid the utilisation of the insurance. The two groups who are suffering the most from the lack of health insurance are women between 55 and 65 years of age, whose husbands retire and then are left without health insurance. They cannot get Medicare until age 65. For many and varied reasons they cannot get on the State Medicaid system. The second group who can get no health insurance are the physically disabled. If they do get health insurance at all, preexisting condition is used. They are forced to sign a rider and the insurance company ends up collecting their money and paying nothing.

I favor the system of National Health that occurs in Canada. We need to also make it profitable for the AMA to make people well rather than continuing to keep them ill and collecting money. We need to emphasize in this country better nutrition, less drugs, less stress and better mental health. It would also help to get food additives out of the food. If you need more examples or comments on this issue, feel free to call me at (616) 385-1597.

Also, please make sure people get the health care and equipment they need, eliminate the red tape and put tough penalties if the system is abused.

Sincerely,

Lois Blocher

Blodgett
Memorial Medical Center

June 27, 1989

United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

As a citizen, health services consumer and as a person who works in the health care industry, I want to support your efforts to help all Americans access high quality, affordable health care.

When I first began working at this hospital fifteen years ago, no one was ever turned away. Both emergency and elective patients were treated and the finances of that care were handled somewhat charitably. If a person could apply ten dollars a month on his bill, so be it: The hospital figured that it was better than a total loss. The bill was essentially written off. Of course, someone else's commercial third party carrier paid for part of our costs on that patient and we were happy to pass those costs along.

From the medical social worker's point of view (my point of view), adjustment (to hospitalization, chronic illness, etc.) was by far the larger problem. Anything else fell a distant second.

The medical community of 1989 is more hostile, in the way that beleaguered individuals and institutions often are. There are still no persons turned away in emergencies. However, the person wishing elective surgery will have a financial plan in hand before he knows the time of his surgery. All of us in medical social work can quote chapter and verse of rearly every entitlement to be found in this country, state and community. As compelling an issue as adjustment to diagnosis and prognosis can be, it is almost never the terror that the financial worries grow to be. People are stunned by the cost of hospital care: They can't believe that we have beds that cost a thousand dollars a day or that there is such a thing as a five thousand dollar deductible for their heart transplant surgery.

There are those who would blame these problems on hospitals and doctors wanting to make more money and passing on exorbitant expenses to our customers. The real fact is that, last year, hospitals (at least in Michigan) gave away more in free care collectively than the Medicaid budget for hospital care. Not only do we write off the hospitalization and/or clinic or emergent care of these folks, we pay for their transportation here, we pay for meals for their families, we pay for their medication so that they won't relapse into the hospital again and we refer them to every appropriate resource in this community that will suit their needs. In my department, we do this with five less staff people than we had five years ago even though our Medicare case mix (at 1.81) is almost 80% more complicated than the "average" hospital patient across the country.

1840 Wealthy S. E. Grand Rapids, MI 49506 (616) 774-7444

Our "problem" patients are not those with large incomes nor are they the poor...although the myriad of disabling forces bearing down on those people is immense. Our hardest to help patients have no insurance, no one is at home to help, they are financially above the criteria for Medicaid, they are seriously, but temporarily, disabled and often are ineligible for entitlements for a host of reasons: too urban, too far outside the service area boundries, too young, not home bound, etc.

And the issue of access! For every agency that starts a new service, another piece of community transport budget is cut. We all agree that good health care should be an entitlement but if a person can't get to that health care, the fact that it is available becomes a moot point. Last month I spent over $350.00 in discretionary funds for bus tickets and taxi rides. If this is a problem in my medium sized urban hospital in Grand Rapids, it must be a nightmare in Michigan's Upper Peninsula or Montana or Wyoming, or any place where both no service and no access are problems.

It occurs to me that legislators who want to know the issues of the uninsured should visit their constituent's hospitals and talk to the front line workers in admitting, the financial office, clinic staff, the social workers and continuing care nurses. These professional people are often in a position to see these patients in the context of their "real" lives. These patients often don't get medical treatment, don't take their medicine and don't call their doctors because they can't pay. These folks are embarrassed: They don't want something for nothing and they are unwilling to incur any more debt in the name of health care.

There seem to be "first world" countries other than the United States who do this so much better than we.

One of my greatest fears is for the financial future of this country. To my way of thinking, taxes must be raised; companies who employ anyone who does not have insurance benefits, must be made to contribute to a fund to help all the people who have "Mc Jobs" and good health care should be available immediately to at least every child in this country. Probably more than anything else, the dire problem of street drugs, poverty and unemployment in this country must be dealt with. I believe that, even in Grand Rapids, Michigan, I'm in a position to see the situation worsen daily. The amount of money that the United States pays in welfare subsidy coupled with the amount spent on illicit drugs, if reclaimed, could not only straighten out huge sections of our health care crises but could likely turn around the national debt.

Please continue to be a vocal, visible leader in the area of access to health care for all Americans.

Sincerely,

Barbara Van Leeuwen
Director, Social Work and Continuing Care

BVL:ct

DEAF

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Marika L.O. Blumenck

Address 51284 Morawski Dr
Utica, Mich. 48087

Representing :

****

I invite you to attach a prepared statement or to submit your written testimony:

Thank you for provedeing these beautiful interpreter

Medical Prof. who doesn't know about deafness:
I urge you to call Sinai Hosp. Hearing Impaired
Prof Services 1-313-493-6274 Dr. Lopez provide
orientation every 6 weeks

Now they are process work of trying to set up
24 hrs. TDD system. Mich. Public Commission
Services. More information call 517-373-0378
work under Division on Deafness under
Dept of Labor

Really Senator doesn't matter the
best services deaf people would get still
not able accessible. What Dr says is important
but how he said it is equal important
One solution make sure Health Service have
money for the cost of interpreter.

Substance Abuse Services are needed for people who happen to be deaf. One-identified program would be wonderful. One place all over Mich. should be able to send there.

Have programs that will teach us deaf how to access services

Thank you

June 25, 1989

Dear Mr. Donald W. Riegle;

I am writng this letter in regards to your letter dated June 08, 1989. addressing the issue of health care and the access to it.

I have a congenital heart defect known as a Mitral Valve Prolapse and a slow heart rate (Bradycardia) I also have Colitis an inflammation of the colon.

I have tried to obtain insurance on three seperate occasions and was turned down each time.

I think myself and others like me should be able to obtain insurance without prejudice at a reasonable rate.

If this can not be done, I hope the government can envoke such a policy for us. We have medicare for the aged and medicaid for poor. How about insurance for the middle income family who has been discriminated because of ill health in one or both spouses. There are insurances available, but you have to go where they tell you. I am talking about the Michigan HMO programs. I think that the individual should have the freedom to pick and choose their own doctors and medical facility.

Sincerely Yours,

Mrs. John Boguszewicz
(313) 282-5033

June 21, 1989

Dear Senator Riegle,

Thank you kindly for the invitation to attend your meeting in Southfield. I certainly would like to be there, but it isn't likely that I can be.

I do have testimony for you though. Although we do not fall into the uninsured catagory, and we are struggling very hard not to be, but the cost we have to pay for insurance (BC/BS) is devastating. Ray gets $758.00 monthly Social Security. Last year up until October we were paying $335.32 every two months which was difficult enough for us, then in October they raised it to $459.62, which is an unbelievable raise. Over the last six years we had been used to 10 to 15 dollar raises but $125.00 is absolutely ridiculous - plus we pay $31.00 monthly for medicare - I don't think many working people could afford this.

1. In 1983, Ray, at 54 years of age had a massive stroke on the left side. He was a member of the Teamsters Health and Welfare and because he had to take an early retirement, he was dropped from their insurance plan and not entitled to their retirement plan as he had to be 57 years old. Blue Cross/Blue Shield let us pick up our own payments and its been a struggle ever since. I suppose you wonder why we don't go else where for insurance - we have tried several times and because of our age and physical contitions we are turned down. So I guess you can plainly see that it is the cost of the insurance available to us which is our problem and believe me it is bad as you can see.

2. We do not have any dental, optical, or prescription coverage at all. We pay all our own prescriptions which is costly. We hadn't had our eyes checked in five years and last year we borrowed $500.00 so we could get much needed glasses. We had been reading for sometime with a magnifying glass. We have not seen a dentist in six years and don't suppose we will unless it becomes an absolute necessity.

3. There wasn't any nursing home or home care coverage for Ray, so I had to quit my job to take care of him. I feel the government would be farther ahead if they paid some money to a family member to care for someone, instead of nursing home care at $1700.00 a month, (at the least) and home care is extremely costly too. From the patients stand point they are much better off, as they have interested people to spend their time individually with them. Nursing homes are over crowded and so poorly staffed that they give such poor care and treatment to patients. In most cases people do better in their own homes and surroundings.

We are now at the point where we will probably have to give up our home in order to survive. This I consider very unfair to us. Ray worked very hard and served his country and now all we get is doors slammed in our faces. Its so hard for me to believe this is the American way, to be so cruel to the older people of this country. We need help Senator Riegle and we appreciate all your efforts in trying to help in these insurance matters.

I really didn't intend to write a book, but you get me started on these insurance and medical issues and I don't know when to stop. I have talked to many seniors who are having problems, so I know I am not alone, but I can only give you our personal problems.

Sometime when you are in your Grand Rapids office and have some extra time I would like to make an appointment to just sit and talk to you. If we can be of any help to you in any way, please call on us at any time.

Sincerely,

Phyllis & Ray Brantner
17 S. Lincoln
Rockford, Mich 49341

616-866-1476

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Helen Brenai

Address 26421 Mary st.
Taylor Mich. 48180

Representing : self

****

I invite you to attach a prepared statement or to submit your written testimony:

Since the shop closed in 1979 I don't have any medical insurance!
It is bad that communist countries take care of their own people?
The middle class is in big trouble in the richest contry on earth!
I know this because I came from Hungary, I escaped in 1957.

[redacted] Mrs. E. Brosch Jr.
22430 Schroeder
East Detroit, MI 48021

June 25, 1989

Dear Senator Riegle,

I'm not uninsured but I could be, and that is frightening. I cannot understand why our country is so far behind other countries when it comes to something as important as health care. Everyone deserves equal high quality health care regardless of income. My husband passed away last summer, & through his company I am allowed to keep insuranse for [illegible] year. It is expensive, over $300 a month. I cannot work because I have an illness. I pray to be able to get a job with insurance benefits. I receive Social Security benefits for one son for 2 more years. I urge my older 2 sons to remain full time college students so they will be covered ~~in~~ by my health insurance. Three members of our family have been hospitalized in less than a year. Because of the deductible I still pay alot for medical bills. I see a doctor several times a month. It costs $50 a visit & only a portion is paid by our insurance.

My oldest two sons attend Macomb Community College because it costs the least. They both were on the deans list. They also work, and one son receives college money from being in the Marine reserves. They also help me at home, & financially. That is alot for them to do, & we should not have the burden of medical bills in addition to our other financial obligations, etc.

In two years, if I am still unable to work, we may not be able to afford health care. Everyone deserves equal health care, not to be homeless, and not to go hungry. I've volunteered to help with the homeless, & it is terrifying to think that we could be in the situation, in this country.

Sincerely. Barbara Brosch

June 28,1989

Dear Senator Riegle,

I received your letter today June 28,1989 so obviously I could not attend the hearing at St. Johns. The letter is dated June 8,1989, why did I only receive it today?

I am not "interested" in the poor uninsured people, I am interested in the working class who are rejected by insurance companies because of existing medical problems. My husband has worked very hard all our married life. I stayed home and raised our children. My husband cannot change jobs because he is burdened with a wife who had a tumor and who has a thyroid problem that so far has ~~been~~ not been controllable under what is considered "normal" treatment.

You Senators & Legislatures have allowed insurance companies to become fat at the expense of the working man. When Blue Cross & Blue Shield don't consider pap smears and mammographies necessary medical treatment for a women, something is seriously wrong. When Prudential Plan didn't cover pre-existing medical problems for those that was not employed on the day Prudential Plan became the employers insurance something is very wrong.

Everyone says "the United States is the greatest place to live", but when you are a minority or immagrant this just is not so. My husband & I have been married twenty-seven years, we have never asked or expected anything for free. We didn't expect day care for our children, we expected to take care of our children, which we did. We have faced all of our responsibilities and I am tired of this attitude that we should have day care and that kids on welfare should wear Reebok tennis shoes and Guess? jeans. It is Senators & Legislatures like yourself who have been around for many years who have allowed our society to think that the government will take care of them.

I intend to divorce my husband so that I will be indigent and qualify for Medicare or Medicaid. Isn't this a wonderful choice I have been given? Don't get me wrong my husband & I love one another very much, we will continue to live together etc., other than our families & attorney no one will know we are divorced. Ain't you proud to know that you are part of a group that has emotionally devastated me, just because I was unfortunate enough to inherit thyroid problems. Thyroid problems unlike alcoholics or drug addicts are not my choice, yet I am penalized, rather my husband is and he has been too good a father and husband to keep him strapped to a job just because I am uninsurable. We have talked to several attorneys and have chosen one to represent us. We will divorce, I will either collect welfare or Social Security because of my illness. Isn't this crazy? But after five years of trying to find another way out of this insurance mess this is the only viable solution.

In 1984 I had a brother incarcerated at Jackson Prison and after several visits there I wrote a letter to Governor Blanchard about the drug problems that existed at the prison and several other things that were taking place there. He wrote back saying in so many words that my daughter and I did not see what we thought we saw. Recently it has come to be public knowledge that there is corruption and drugs at Jackson Prison— there is rampant drug & money abuse at Jackson Prison, not just a remote corrupt guard. When prisoners see this constant cover-up is it any wonder that when they come out of prison they commit crimes. Our penal system teaches them everything they didn't know about crime & corruption. The really scary part of this situation is that 90% of our prisoners will return to live in our society—maybe our next door neighbor. The total lack of dignity & respect in our prisons is the reason that so many return to prison.

While waiting for a test at Beaumont Hospital the women sitting next to me started talking about her wonderful son. She explained to me that this son quit his job and started selling drugs so that she could have enough money to get the best medical care, she had cancer. She told me how guilty she felt but because she had had a double mastectomy several years ago she was uninsurable and when she became ill with bowel cancer which she was being treated for now nobody would do anything without an insurance card or money. She was feeling so very guilty but she didn't know what to do. When a young man of twenty-five or so wearing a beeper appeared I immediately knew it was her son. He apologized for being a few minutes late, gave his mom a hug and told her how wonderful she looked. My heart went out to both of them as they walked out of the hospital into the rainy dreary day. I thought to myself and they call America the greatest country in the world.

It is time we quit giving to all there foreign countries, protecting Japan and all the other things we do for other countries and take care of our own. I hope that you think about the fact that you played a part in making a drug dealer so that his mother could get good medical treatment. That you played a part in destroying a good solid family. You have made me get a divorce so that I can get needed medical attention. Maybe I should suggest to my twenty-three year old son that if he sold drugs he could make enough money to pay for my medical needs and then his father & I wouldn't have to divorce. No-I'll do it the legal way but do you understand Senator Riegle what you are doing to good, hard working people? You better realize soon or it will be too late for any of us.

Oh yes, my brother who served time at Jackson Prison was a highly decorated Viet Nam vet. He came back from Nam needing mental help but you guys didn't think that was necessary either. Prisons are full of Viet Nam vets.

Thank you for reading this, yes I am angry.

Jacqueline Jane Budde
5157 Brunswick
Utica, Michigan 48087

(over)

I have just heard on the news that Dennis Ditko will not resign & will take care of business from prison. Sure a recall will be instituted and we will be forced to spend alot of money to get him out & ~~[illegible]~~ elect someone new. Nothing is sacred any more. What a poor state of affairs. We can afford to pay a drunk who refuses to admit he's a drunk — alcoholism is not a disease — it is a choice one makes. Cancer, thyroid, diabetes &c. are diseases and we don't get ~~get~~ a choice.

We can now burn the flag, talk filthy over the phone but we refuse to pay for the sick. We make it impossible for some to get off welfare and disability because all these wonderful part-time jobs you have allowed, part ~~time~~ time jobs give no benefits. Michigan is a state headed for disaster. How is it that we only allow the President of the United States 8 years but we allow the mayor of Detroit unlimited years? Isn't it amazing the financial gains Coleman Young has made while in office. Now you tell me how can someone amass the kind of money Coleman has and not be indebted to someone? It is impossible but you politicians allow it. Wake up and look around. Ten years from now we will have anarchy right here in the good old U.S.A.

PERRY BULLARD
MICHIGAN STATE REPRESENTATIVE

HOUSE OF REPRESENTATIVES
STATE CAPITOL BUILDING
LANSING, MICHIGAN 48913
(517) 373-1289
373-2577

CHAIR, JUDICIARY COMMITTEE
COMMITTEE MEMBER OF
LABOR
SOCIAL SERVICES AND YOUTH
TAXATION

June 21, 1989

Senator Donald Riegle, Jr.
705 Washington Square Building
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

Thank you very much for your invitation to appear at the hearing of the Senate Finance Subcommittee on Health on June 28, 1989. Unfortunately, I will be unable to attend, as the State House of Representatives will be in session that day.

I applaud your efforts in holding this hearing. Our present health care system is a national disgrace. Although quality care is available to many, we have more than 1,000,000 Michigan residents with no insurance coverage, and an additional 1,000,000 residents who are underinsured. We need look no further than Ontario - although we could also look at Sweden, West Germany, Japan or Great Britain - to see that is possible to provide access to health care for all. Each of these places has a system of universal access while spending a lower percentage of GNP on health care than does the United States. Each country also has a lower infant mortality rate and a higher life expectancy than we do.

But the importance of this hearing is not to compile statistics, telling as they may be. For statistics do not reveal the indignity, the injustice, the suffering felt by those who do not receive adequate health care. It is their cries that must be heard. Tears of the mother who loses her baby because pre-natal care was not available, these tears reflect the true cost of our present system.

Solutions exist. The $17.5 billion dollars we spend in Michigan each year for health care can provide benefits for all. But we need the political will to restructure our health financing system. Federal action would be ideal, but we cannot wait. I am working on a plan of universal access for comprehensive health care for Michigan residents, a plan to be known as Michicare. I have enclosed an outline of the plan.

The health of our nation depends on the health of its people. We must do better.

Thank you very much.

Sincerely,

PERRY BULLARD, Chair
House Judiciary Committee

Recycled Paper

MICHICARE:

A HEALTH PLAN
FOR
MICHIGAN'S FUTURE

REPRESENTATIVE PERRY BULLARD
CHAIR, HOUSE JUDICIARY COMMITTEE

SELECTED HEALTH CARE FACTS

INSURANCE COVERAGE

- Over 1,000,000 Michigan residents have no private or public health care coverage. At least as many are insured only part of the year or have coverage and resources inadequate to meet possible health care needs.

- Of the uninsured, 350,000 are children or adolescents. Young adults between the ages of 19 and 24 have the highest rate of uninsurance, 25%.

- At least half of the uninsured between the ages of 19 and 64 are employed. Two thirds of the employed uninsured are employed full time.

INFANT MORTALITY

- Michigan ranks as 12th worst of fifty states; over 11 deaths per 1,000 live births.

- For Blacks, Michigan has the 3rd worst rate; over 22 deaths per 1,000 live births.

- There are 16 countries with a lower rate than the United States.

COST OF CARE

- Michigan health care costs are estimated to be $17.5 billion per year, more than $1,900 per capita.

- Total expenditures include more than $5.5 billion in government funds and more than $7.5 billion in health insurance premiums.

- In 1986, the United States spent 10.9% of its GNP on health care. Canada spent 8.6% of its GNP on health care with universal access.

TRENDS

- Employer health care costs rose over 18% in 1988. There is intense pressure to increase cost sharing, to reduce benefits, to experience rate monthly and to institute individual underwriting in group plans.

- Since 1978, Michigan has seen a decrease of 240,000 manufacturing jobs and an increase of 200,000 service jobs. The number of uninsured is rising; a substantial factor is the increase in the employed uninsured.

- GNP spent on health care in the U.S. has risen from 5.3% in 1960 to 11.2% in 1987. Canada tracked the U.S. until 1972, the year when universal access was fully implemented.

MICHICARE - FIRST PRINCIPLES

I. UNIVERSAL ELIGIBILITY

  A. Actual ability of each person to participate

II. COMPREHENSIVE SERVICES

  A. Prevention, diagnosis, care and treatment
  B. Prevention through education, services and taxation

III. QUALITY CARE

IV. COORDINATED, EFFICIENT DELIVERY SYSTEM

V. CONTINUUM OF CARE

  A. Forestall institutionalization

VI. ACCESSIBLE SERVICES

  A. Program design sensitive to cultural, linguistic, informational and mobility barriers.

VII. ABSENCE OF DISCRIMINATION

  A. First in need, first served
  B. Irrelevance of race, sex, age and income

VIII. COMPREHENSIBLE

  A. Information readily available

IX. DIGNITY OF PATIENT

  A. Consent to treatment
  B. Confidential records

X. SIMPLE AND EQUITABLE FINANCING

  A. Single system
  B. No need for supplemental insurance

STRUCTURE OF MICHICARE

I. ELIGIBILITY

- A. All residents of Michigan
- B. Thirty day residency requirement except for newborns/adopted children
- C. Out-of-state emergency care covered during vacation/business trips

II. COVERED SERVICES

- A. Full range of services for prevention, diagnosis, care and treatment of disease, condition and injury
- B. Services include mental health, institutional and community based long-term care

III. ADMINISTRATION

- A. Third party administrator selected by competitive bidding, or State of Michigan

IV. PROVIDER PARTICIPATION

- A. Health care professionals - full payment directly from plan on a fee-for-service or capitation basis
- B. Health care facilities - budget received directly from plan

V. FINANCING

- A. Federal funds presently spent on health care in Michigan
- B. State funds presently spent on health care
- C. Cost savings over present system
  - Reduction in administrative expense, advertising costs, insurance policy commissions, premiums for valueless policies,misuse of system (e.g. use of emergency room for non-emergencies), unwanted care, profit; maximize preventive health/early intervention
- D. **Additional state funds**
  - Reduction of health related tax expenditures (e.g. employer deduction for health benefits), increase in tax revenue and decrease in welfare costs through higher employment, raise in excise taxes on products contributing to health needs, key amount of personal tax exemption to income, shift employer cost from premiums to tax

MICHICARE SERVICES

PREVENTIVE HEALTH

- Immunizations
- Periodic exams
- Well child care
- Health screening
- Health education
- Vision and hearing exams

DIAGNOSTIC SERVICES

- Laboratory tests
- X-rays

AT-HOME SERVICES

- Hospice
- Home health
- Respite care

OUT-PATIENT SERVICES

- Acute care
- Mental health services
- Transportation

IN-PATIENT

- In-patient care
- Mental health in-patient services
- Short and long-term nursing home care

ADDITIONAL ITEMS

- Eyeglasses
- Hearing aids
- First aid supplies
- Prescription drugs
- Durable medical equipment

The Honorable Donald W. Riegle Jr.

Thank God for you - We need more people like you to try to get this Country to do something for the old and indignant.
America should be ashame for not furnishing every Citizen Health Ins. regardless to their Age.

Some jobs do not furnish Ins to people after they retire - then they have to pay for non group - this type of Ins. does not cover Prescription plus only the very rich can afford Health Ins. Non Grp. - The system let Caleb steal Blue Cross Blue Shield money then they put the cost on the poor people
Medicine is too expensive for the averag person to pay for some time one prescription cost $60 or 70 dollars for 1 mo supply. This Country takes care of every Country but its own. I think this is a disgrace - Charity should begin at home - then spread itself abrood.

I pray that something can be done to help every one in this country to have health Ins. regardless to age. God Bless you in this endeavor.

Antoinette Bush

June 21, 1994

Dear Senator Riegle,

I am writing in reply to your message concerning our health care system. As a single parent, earning a living as a self-employed individual, I am well aware of the difficulties involved.

My former husband does carry our two children on his employers plan, which does ease my burden a bit, but I have an individual ins. policy on myself, at no small cost.

With the exception of my rent each month, my ins. payment is the next largest expense.

I have an 80-20 policy with a [illegible] deductible, which as you are aware would mean I would still be responsible for quite a large amount of money should I ever need to be hospitalized.

I certainly hope that

never happens, because along with whatever balance I would be responsible for, I also would have no income, because of my self-employment.

My annual income is low, but I am able to care for my children and myself without being another statistic on Michigans welfare system.

That makes me proud, and will hopefully be passed on to my children.

There will be a time in my life, when I am in a position to better my income as my children get older and become more responsible young people.

But for myself right now, it is of greater importance to be a major part of their lives, rather than be absent 40-50 hrs. a week, shifting my responsibilities to a lobbyist?

I'm not real aware of your options concerning our health care system, but I do know there must be a way to get most individuals [illegible].

I would not be against a health insurance plan, but my income would soon be eaten up as the insurance money is great.

Please keep us informed as to the decisions being made within your committee meetings.

Thank you.

Sincerely,
Marcia J. Busick

CALHOUN-BARRY GROWTH ALLIANCE

632 North Avenue
Battle Creek, MI 49017
(616) 965-3020

June 27, 1989

Donald W. Riegle, Jr.
U.S. Senator
Suite 716 Federal Building
110 Michigan Avenue, N.W.
Grand Rapids, MI 49503

Re: Senate Finance Subcommittee on
Health for Families & the Uninsured

Dear Senator Riegle:

Thank you for inviting me to your subcommittee. Unfortunately, I will not be able to attend tomorrow's meeting, however, I did want to make some comments on my concerns.

Most of these concerns center around your belief that "high quality, affordable health care should be available to all Americans and their families." This is certainly not the case now and the way health care costs are escalating, I doubt it will be the case in future years unless something is done.

We are rapidly reaching the point where you either have to be very rich to afford to be sick or very poor so that the government will pay all or most of the costs.

When older couples who have worked all their lives as contributors to our system, have to use their life savings to pay for health care costs - something is wrong. Most of these people have a great deal of dignity, and the system, at the very least, owes them the right to live out their retirement years without worrying about health care costs.

One of the major reasons younger people want to remain on public assistance programs is their fear of losing the medical benefits available to them. I realize that some progress is being made to address this situation. The fact remains that they stay on public assistance as long as possible, while the rest of us Americans work to support these programs and in many instances pay a good deal of our health costs out of our own pockets.

I do not have a large list of policies that I believe are necessary to address these problems. My closing remarks are simply this:

1) The government has to stop supporting programs that create incentives for people not to work!

2) The government, in concert with the private sector, should develop a system of health care that will allow our senior citizens to live out their lives free of astronomical health care costs.

Thank You for listening.

Sincerely,

Bob Quadrozzi
Executive Director

RQ/tb

June 29, 1989

Dear Senator Riegle,

As you can see by the date I received notice on the hearing for the problem of access to health care for uninsured individuals a day late. But do accept this written opinion as testimony to the fact that you are on target. There is a need & I am one of those uninsured individuals.

I've been divorced for 6 years now & have my own very small sewing business, at home, so that I may be available for my son. I live below poverty level & have written to you before in hopes of getting help with getting my child support issue resolved. That in itself has been going on for 2 years. RIDICULOUS!!

As far as the health care issue yes do something. If I were to get ill - there would be 2 more people on welfare rolls. Myself &

my [illegible]. If I need any kind of medical assistance Dept of Social Services would be called. It's just that simple.

I haven't been to a dentist since I've been married simply because of lack of funds. It's just that simple. These realities I face every day. It's not easy & I depend on God for support because it just doesn't seem to come from anywhere else. And in this country

Shameful!

Sincerely,
Barbara Fisher Cameron
6143 Berry
Westland, Mich 48185
Phone (313) 728 3536

CENTER OF HANDICAPPER AFFAIRS
A Center For Independent Living

918 Southland, Lansing, Michigan 48910
Voice Number 393-0305 • TDD Number 393-0326

June 28, 1989

The Honorable Donald W. Riegle, Jr.
United States Senator
700 Washington Square Building
109 W. Michigan Ave.
Lansing, Michigan 48933

Dear Senator Riegle:

I am interested in your hearing that will focus on the problems of health care for uninsured individuals. I am unable to attend this hearing but would like to receive information on issues surrounding these very important health care subjects.

Some of the best health care in our country is happening in the homes of families with children who have severe multiple handicaps or are chronically ill. The parents of these children are not only the care givers, but are also self trained and "on call" around the clock, every day of the year. Insurance, including medicaid, does not provide any relief for these parents in order to maintain support systems that will prevent eventual burn out.

Through a recent survey of 163 families with handicapped children living in the Lansing area, we have discovered that over 33 percent are single parent families, and 19 percent have average incomes of less than federal poverty levels. One in every four children require assistance with dressing and toileting, and one in seven with feeding. In addition, over one in ten require assistance with a behavioral management program. Of our surveyed families we found that 42 percent had been hospitalized one time in the previous year (24% two times and 23% four or five times).

Can regular respite care provide the break that is necessary for families to maintain high quality care giving capabilities? Give families the energy to pursue family stability as a high priority? And to provide for a child with handicaps, a stable, loving environment in which to live and grow?

Encouraging self-determination through Public Awareness, Peer Support and Independent Living Skills Training.

We maybe cannot answer all these questions now, but are trying to collect enough data through our Lansing Area Parents' Respite Project (funded by the Department of Health and Human Services) to show that respite services can make a difference. Can we decrease the need for frequent hospitalization, institutionalization and the stress leading to parent burn-out? We cannot do this alone. Respite care is still not affordable to many of our families. Eventually we will need insurance and medicaid to provide benefits that will reinforce respite care and home health care.

I realize that legislation is addressing some home-health issues for the elderly population. Many of the issues that I have addressed here are quite similar in nature. Could there possibly be method of joining the concepts, therefore, having legislation addressing both population groups?

I, and the parents that I represent, would be interested in hearing your views and learning more about home health insurance issues. If we, or our data information, could be of further assistance to you, please let us know. Thank you for your continued interest and service.

Sincerely,

Judith Wagner

Judith Wagner, M.S.
LAP Respite Project Director

Senate finance subcommittee on health
Donald W. Reigle, Jr.

Yes Am very much concerned about health insurance in America.

I have a 31 year old daughter who had NO insurance & had to have a bad infected avory removed. Her health was so bad (ashma & this infected ovory & nerves) she could not hold down a part time job to support herself. Now she is able to work & no insurance yet but can not pay these big medical bills & buy medicine & pay Rent & run a car. She sure could use some help on health insurance. I have a son who is going to college & not able to afford health ins. If he gets sick we have to help him & we are trying to save towards our retirement. He sure could use some help.

Thanks for listening
D. M. Champine
Harrison TWP. MT Clemens MI.

Tuesday - June 27, 1989

Honorable Donald W. Riegle, Jr.
United States Senator
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, MI 48226

Dear Senator Riegle:

Thank you for the opportunity to comment on the need for medical insurance. I've had the following personal experiences recently:

1. Our son graduated from college - then no longer covered by our insurance -- we wound up paying Blue Cross $253.40 every two months for an individual subscriber policy which offered few benefits unless he was hospitalized.

   Further, his first job did not offer immediate medical benefits, so we had to continue paying for medical insurance until he found another job which offered medical benefits.

2. Due to poor health, my husband retired last Fall at age 59 - his health benefits have decreased considerably (when we need them the most), and his premium payment just doubled!

I appreciate the attention you are giving to this serious problem of providing adequate medical coverage for all Americans.

Sincerely yours,

Bobbie R. Christy

Mrs. Bobbie R. Christy
17537 Ray
Riverview, MI 48192

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Susan Cooley ACSW
Address 2980 Verle
ann arbor, mi. 48108
Representing : Self

****

I invite you to attach a prepared statement or to submit your written testimony:

MEDICAL CARE does NOT equal HEALTH CARE!

"Medical care may be a **part** of "Health Care." Health care, properly practiced includes a variety of professional services directed toward regaining and maintaining health. Looking toward the medical establishment alone for guidance in providing health care for all U.S. citizens will not result in innovative approaches to health care. Medical expertise and technology can provide stunning successes in treating specific illnesses. No one can argue with the advances modern medicine has made. But it is time to recognize that comprehensive care of people's health can prevent or reduce the effects of illness, can speed recovery and more important, can deal better with the multitude of long term chronic conditions of ill health for which medical science has no good answers.

Who, for example, has counseled with Arlene Dilloway of Imlay City, regarding her diet? In detail, I mean. Who has helped her adapt her cooking styles to the needs of a diabetic diet? Who has considered the research which Dr. Robert Giller relates in Maximum Metabolism, that guar gum can help regulate blood sugar levels (p.53)? Most physicians do not study, and are not interested in, nutrition. Who has talked with Arlene about the emotional factors in her disease? Who has taken the time to listen to the intricate and complex psychological issues, to her fears, to the many emotional states which can predispose her to further complications of diabetes? Has anyone checked out the possibility (more likely the probability) that a bodywork practitioner can help Arlene **feel** better and probably even **be** better? Who counseled Bavid Dilloway in dealing with the stress and worries of his wife"s illness so that he could help her?

I'm not talking about sending Arlene to a psychiatrist, nor to one appointment with the nutritionist at the U of M Hospital for yet another sizeable medical bill. I'm talking about a different approach to health care. I'm talking about services which **automatically** include initial screening by a family physician, holistic physician or an osterpathic doctor and further evaluation by a master's level social worker and a nurse practitioner. Such a screening would provide a much more comprehensive picture of a total physical/mental/social condition. If referral to a specialist were necessary the physician would make it. The patient should have access to a wide variety of professionals: psychologists, social workers, nurses, occupational therapists, bodywork practitioners, nutritionists. If you hadn't noticed, each person's health problems are unique and have causes unique to that individual. Each illness tells the person something about themselves. People need help in understanding what the body's messages are and most medical doctors, with today's modern training, are the last professionals to even conceptualize illness in this way. Love Medicine and Miracles, by Bernie Siegel M.D. is an enlightening book which discusses the biases of an ossified medical profession.

If the government waits until the medical profession solves the health care problems, the present appalling conditions will continue. The government could just as easily approach the national organizations of the professions mentioned here to obtain input into creative thinking about a new, better, and less expensive system of federally insured comprehensive health care. The Community Mental Health system, as mandated by federal law could be modified to be a basic model of a way to divide responsibility for health care by state and county. A similar sysstem could be devised to provide comprehensive health care. funding would have to follow service delivery more faithfully than mental health funding followed community mental health centers. The inadequacy of funding in mental health centers to meet the demands of the mentally ill and emotionally disturbed population is another, dismal, story. In no case will health care services by inexpensive, no matter what delivery system is used. I would rather see my tax dollars go into a well planned health oriented care system which had intrinsically preventive services, than into any degree of the current medical practice system in the United States.

Thank you for listening.

Susan Cooley ACSW

Susan Cooley ACSW
Director of Social Work and Community Services
York Woods Center
Box B
Ypsilanti, Mich. 48197

Health care in the United States has become a rigid and extremely expensive system. It is not receptive to new ideas and not flexible enough to explore alternative treatments. If health care is to become more reasonably priced, and if prevention is truly to become a health care concept, there must be professional, nonphysician, staff who are able to assess and treat the related causes/effects of illness. There are social situations that aggravate and perpetuate illness in poverty classes. There are emotional and psychological factors which aggravate and perpetuate illness in all classes. There are attendant physical/physiological conditions which complicate the healing of illnesses.

A structure for federally reimbursed health care could be devised which would promote comprehensive health care at lower cost than most care provided now. Clinics could be structured so that a family physician screened all patients. Ancillary staff would complete the evaluation of the patient. Ancillary staff would include registered nurses, nurse clinicians, masters level social workers, Ph.D psychologists, occupational therapists, and bodywork practitioners. The physician would designate the further evaluations to be done and the professional staff would carry out those evaluations. In rural areas where not all of these professionals are easily found, standards of staffing would have to be more flexible. The physician would be the referral source in instances where a specialist were needed.

The AMA will resit any effort to change the structure and orientation of medical care delivery systems. Each of the professions mentioned here has its own professional organization which would respond to a federal mandate to change the health care system, and create a more flexible and responsive delivery system. The initiative to change the present system of health care delivery will not come from medical doctors nor their agencies and organizations, so it will have to come from a different source. Since the federal government has a broad concern for the welfare of all citizens, it is a logical choice for the iniation of change.

Susan Cooley ACSW
Director of Social Work and Community Services
York Woods Center
Box B
Ypsilanti, Michigan 48197

Susan Cooley ACSW
2980 Verle
ann arbor. mi. 48108

COLDWATER OBSTETRICS AND GYNECOLOGY, P.C.
Vangala P. Reddy, M.D. **Edward C. Lake, Jr., M.D.** **Jeffrey C. Custer, M.D.**
235 E. CHICAGO STREET
COLDWATER, MICHIGAN 49036

TELEPHONE 279-8465

June 27, 1989

Donald W. Riegle Jr.
705 Washington Square Building
109 West Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

This is in regards to the "Senate Finance Subcommittee on Health" hearing that you are holding tomorrow to address problems confronting health care recipients. I am a young obstetrician/gynecologist who has located in Michigan approximately two years ago. Already I am starting to limit my practice of obstetrics for private patients, as well as Medicaid patients. I am doing this simply because I have more patients than I can possibly care for. Presently, my clientele is greater than one-third Medicaid, and the number of Medicaid obstetrical patients of this county, Branch County, is steadily growing as it has in the past. The number of patients that are not eligible for Medicaid and are unable to afford care is growing at even a faster rate, this frequently includes the Amish. The bottom line is, we simply need more physicians in this rural area to handle the private, the Medicaid, and the uninsured indigent, and we need the NOW. Our hospital, Community Health Center of Branch County, has been actively recruiting obstetric/gynecologists to this area for many years. Over the last two years there has simply been three candidates. Only one of these three candidates measured up to our qualifications, and this person decided to go elsewhere. There is a drastic need to change the climate of medical care in this State, to encourage physicians to locate in Michigan. This cannot happen unless several things occur:

1) Malpractice rates must drop.
2) Receive malpractice immunity for charitable services for which fees are not collected.
3) Reimbursement rates must increase to at least match inflationary rates with Medicaid and Medicare.

I am interested and concerned in keeping a high standard of quality health care in the State of Michigan. I feel that unless the above requirements are met, it will be impossible to recruit new qualified physicians to Michigan. Worse yet, I am afraid we will lose many of our highly qualified physicians that are presently here. I would appreciate your concern and consideration in this matter.

Sincerley,

Jeffrey C Custer MD

Jeffrey C. Custer, M.D.

JCC:cj

COMMISSION ON AGING GRATIOT COUNTY

110 S. Main • Ithaca, Michigan 48847-1466 • Phone 875-5246

July 12, 1989

Hon. Donald Riegle
United States Senator
700 Washington Square Bldg.
Lansing, MI 48933

Dear Honorable Senator Riegle:

I would like to address the issue of access to health care for uninsured individuals. I realize this letter is late in coming but I was not able to attend the hearing held June 28, 1989.

As the former Case Manager and now Director of the Commission on Aging I have talked with many frustrated individuals, especially between the ages of 50 and 65 who are not covered by any type of affordable health insurance. This situation not only affects our clients we are working with but also some employees who are employed under the Title V Work Program through the federal government.

The working poor individuals are very frustrated because health care coverage is available but it is not even close to being affordable for them. It is their hope that they will obtain higher paying positions with benefits but the question is how realistic is it to expect advancement. It is hard to prove age discrimination but it certainly does exist.

This is a serious problem which will continue to grow as health care costs increase making it more difficult for even moderate income families to afford health insurance. Adding to the problem is the fact that more employers only offer part time positions with no benefits as is the case in this area.

I really don't have any answers to this problem but I do talk with many individuals who really don't have any alternatives and therefore just simply go without benefits. Having been in that situation myself about ten years ago, I know that it is a very insecure feeling and as a person becomes older I am sure the feeling becomes much greater.

I appreciate the opportunity to express my views on this terribly important problem and hope to hear that someday soon affordable health insurance will be available for all Americans.

Respectfully,

Craig L Zeese

Craig L. Zeese
Director

CZ/js

L.M. COOK
1271 WIYALE AVE
FLINT MI. 48505

FLINT OFFICE
89 JUN 26 AM 9 11

DON RIEGLE
US SENATE

DEAR SENATOR-

I CANNOT BE AT YOUR MEETING DUE TO ILLNESS IN THE FAMILY BUT I WILL TRY TO EXPLAIN MY SUGGESTED HEALTH CARE PLAN. AT PRESENT WE ARE GIVING FREE HEALTH CARE TO ALL THE ARMED SERVICES & MERCHANT MARINES. WE COULD DO THIS FOR THE NATION & SAVE MONEY IN MEDICARE & BLUE CROSS & BLUE SHIELD, ALL DOCTORS & STAFF WOULD BE GOV. LICENSED, HOSPITALS LEASED TO THE GOV. DOC'S & HOSPITALS WOULD HAVE TO COMPLY OR GO OUT OF BUSINESS AS ALL GOV. HOSPITALS WOULD BE FREE TO THE PEOPLE, WHICH WOULD ELIMINATE THE MONEY GRABBING, ALSO LIKE IN THE SERVICE THE DOC'S WOULD GET THEM WELL QUICKER SO THEY WOULDN'T HAVE TO WORK AS THEY WOULD BE ON SALARIES ACCORDING TO RANK - NO EXTRA GOUGING FOR BIG MONEY - THE TAXES TO DO THIS WOULD BE LESS THAN THE PEOPLE ARE PAYING FOR INS. SINCE IT WOULD COME FROM ALL THE PEOPLE

MY BOY WAS IN THE HOSPITAL 19 DAYS. THE INS.. PAID $19,000.00 – HE WAS IN AGAIN FOR 9 DAYS THEY PAID $8,000.00 AGAIN FOR 10 DAYS AND I HAVEN'T RECEIVED THE INS. STATMENT YET BUT I SUPPOSE IT WILL BE AROUND $9,000.00. I DO THINK GOV. RUN HOSPITALS COULD DO BETTER – THE PEOPLE ARE THE NATION AND THAT INCLUDES ALL THE PEOPLE. IF THE DOC'S + HOSPITALS ARE ALLOWED TO ROB THE PEOPLE THEY ARE MAKING THE NATION POOR – MY BOY WENT TO THE HOSPITAL DENTISTRY 3 TIMES + ALL THEY DID WAS CLEAN THEM + CHARGED THE INS. CO. $840.00. ONE HOUR EACH TIME FOR 3 HRS. WOULD BE $280.00 PER HR. I THINK THE GOV. COULD DO BETTER AND PROTECT THE NATIONS HEALTH. I HAVE INS. THAT PROTECTS ME + MY FAMILY BUT THERE IS A LOT OF PEOPLE OUT THERE THAT DON'T HAVE THAT PROTECTION. MY SUGGESTION IS TO HELP THOSE IN NEED. SORRY I COULD NOT ATTEND YOU MEETING. MY RETARDED BOY HAS TO HAS TOTAL NURSING CARE + CUSTODIAL CARE WHICH I AM TRYING TO GIVE HIM.

RESPECTFULL YOURS –
Lonnie Cook
GM RETIREE
EX US NAVY QM3/c

PS THANKS FOR REMEMBERING

June 23, 1989

Dear Senator Riegle:

In response to the letter I received from you on June 23, 1989, regarding to the health care of the uninsured in the State of Michigan; I have written a proprosal on this topic, which I have submited to you on the following page. Thank-you very much for considering my opinion on this matter of health care for the uninsured.

Sincerly,
Cynthia Concato
Cynthia Concato

I propose that the State of Michigan take a new direction in the area of health insurance programs for the uninsured.

REASONS:

1. UNINSURED

A. Some companies do not offer medical insurance to their employees, even though the workers average 30-40 hours of work. If the employer does have an insurance package to offer,the employee has to pay an exorbitant fee for this package in relationship to his/her pay (maybe $4.00 a hour).

B. Or some companies offer only part-time work, up to 30-35 hours a week, so that the company does not have to pay for the employees' medical coverage. Some major companies have chosen this route to alter the employees' benefits (even after years of service), to cut their overhead cost and increase their profits.

C. Without the proper medical credentials most hospitals will not receive a patient. Example: A stroke victim was taken by ambulance to three different hospitals before one would receive him. He had worked all of his life without receiving one cent of state aid, but because he did not have the right medical credentials he was refused immediate help.

D. With the rise of crime and violence, the inflicted victim is left holding the bag of medical receipts, responsible for all costs and debts inflicted on him by his/her offender(S).

It is for these reasons that I propose that the State of Michigan implement a medical insurance program for the uninsured people of Michigan. Medical Incurance cost ......$300.00 per year.." or with a sliding scale payment, according to yearly income." All the money that was not paid out in claims could collect interest. The best approach would be Socialized medicine, which seems to be working well in other countries.

I propose that the State of Michigan also implement a no-fault car and home insurance program, to be initiated and operated by the state, for the following reasons: Today most of the insurance businesses are big profit makers. They do not want to pay out the claims that they proclaim they will. When the insurance company does pay the claim, the company either raises the payments of the customer, or the customer is dropped by the company (often after 15-20 years of claim-free insurance payments).

Sincerly,

Cynthia Concato

Cynthia Concato

July 1, 1989

Senator Don W. Riegle, Jr.
United States Senate/Wayne/Monroe
1850 McNamara Federal Bldg.
477 Michigan Ave.
Detroit, Mich 48226

Re: YOUR CORRESPONDENCE-JUNE 8, 1989
FINANCE SUBCOMMITTEE ON HEALTH INSURANCE HEARING

Dear Senator Riegle:

This is my written testamony regarding the lack of adequate, affordable Health Care here in America.

Since my husband, Willie Cooper was layed off two years ago from the GM, Clark Street Plant, it has been very rough getting to see a doctor.

We lost our health insurance and my husband has been having chest pains and his legs and ankles swell up alot and he doesn't have the money to go to a doctor.

I can no longer be effective on my job assignments when answering the phones because I cannot hear out of one ear very well. I had an ear infection and didn't have the money nor a place to go get it taken care of. When I go to my dentist, I must use our food or utility bill money to pay him. I had a severe gum infection and I need $65.00 for a cleaning a scaling job on my teeth. It is embarrassing, people back up when I talk. I have a chewing tooth missing and it cost $1,000 without insurance to replace it and $500.00 with insurance. I cannot afford neither.

I make $9.00 an hr. on assignments for Kelly Services and when I'm off I get unemployment, but I still lag behind on my utility bills and I must constantly make payment agreements to keep the services on. There are (five) people living in this house so $9.00 hrly is not enough.

I went to a clinic in Westland and paid $50.00 for a Dr. to tell me that there was something wrong but he could not do tests because I don't have insurance, now I go to Hutzel, but they keep billing me and they want to give me alot of medication which I won't take. It covers up what is really wrong with you and makes things worse. I'm not a person that takes drugs. One asprin puts me to sleep and anti-inflammatory medications gives me severe stomach cramps.

The bills are stacking up so high, I just rubber band them and put them in a box in the closet. Eventually, I will have to file bankrupcy to be able to buy food and pay utility bills and housenote around here. My husbands little job doesn't matter because he is being garnisheed.

I think the state should give all peoples from the McDonald workers on up free medical insurance, or take $5.00 a month deductions out of everyones pay checks to cover the costs. It is not fair or right that a person like myself who goes to work sick and in pain, I don't cheat, lie or steal, I'm an honest mother trying to feed her family and I can't get health insurance. Drug addicts, prostitutes, pimps, murderers in prison all get excellent health and dental care and I am completely forgotten. Workman's Comp has even stop giving me theraphy on my arthritic back caused by an injury on the job. I now have arthritis all over and must go to work in pain and sick to the stomach and I get dizzy alot too.

Something needs to be done to help people like myself, my husband and my grown

Senator Don W. Riegle, Jr. *-2-*
July 1, 198[illegible]

sons, one has asthma, the other seems O.K. but hasn't had a check up in four years. They need health insurance like everyone else. One is in college. My marriage has been on shaky ground because of all these problems we're having physically, or healthwise. I believe my husband has swollen ankles because of a heart ailmentbut he doesn 't have themoney to get it checked out.

Please consider some type of legislation to help people like myself forgotten and thrown asise when it comes to getting health care. If we pay taxes, we should have health care privleges too.

Sincerely,
Mrs. Linda Cooper Linda Cooper
29042 Oakwood
Inkster, MI 48141
(313) 721-4225

P.S. On top of having to pay some of these doctors, I had to pay for any and all perscriptions. I didn't get one filled because it costs $60.00.

I dont like running
OUT OF Food because
I have to pay for
med. care. There just isnt
enough money.

I have a '77 car That needs
[illegible] on it, Struts, Tires
Engine work & carburation
work but I dont have the
money.

CRITTENTON

6/27/89

Senator Donald W. Riegle, Jr.
United States Senate
1850 McNamara Federal Bldg.
477 Michigan Ave.
Detroit, Michigan 48226

Dear Senator Riegle,

I received you letter asking for comments regarding providing adequate health care to the uninsured, poor, and indigent. As an emergency physician I am on the front line of providing health care for anyone who comes in to my emergency department. A significant portion of that care is uncompensated and rendered to this very segment of our society which you are addressing in your hearing tomorrow. As such I feel well qualified to render an opinion on this issue. Unfortunately I will be in the emergency department at the time of your meeting at St. John's church. I would therefore like to make my opinions known to you in this letter as briefly as I am able.

No physician is unaware of the difficulty in providing health care to all segments of our society. We have the most advanced medical system in the world and also one of the poorest distributed system of any Western nation. As more money is taken out of the Medicare/Medicaid budget each year (i.e. the recent proposal to strip $1 billion dollars from that budget proposed by Senator Pete Stark) emergency departments bear a greater proportion of care for those persons outside the traditional health care system. Unlike any other type of medical practice the emergency department sees all patients (and at least in my department with no exceptions), is open 24 hours a day, and 365 days a year. No matter how big an existing bill a person may still owe me if they come to the emergency room they will not be turned away. If a person can not afford a private doctor they come to the emergency room. If a physician has a patient who has not paid their bill they send that patient to the emergency department because we never turn anyone away for financial reasons.

At the same time I assume all the regular risks of malpractice and have all the same overhead fees of liability insurance, billing, equipment costs, nursing

CRITTENTON HOSPITAL
1101 W. University Drive • Rochester, MI 48063 • (313) 652-5000

salaries, and costs for all the other personnel it takes to staff an emergency department. Now I admit many of those costs do not directly come out of my pocket but, are born by the hospital. However, as a hospital based physician I am so integrally tied to the hospital the differentiation is a moot point. As it stands now it costs me more to generate a bill to Medicaid and pay for my malpractice insurance than I will receive after waiting 6 months from the Federal Government. Therefore each Medicaid patient is treated at a significant financial loss.

I would like to provide the finest level of health care to all patients regardless of their ability to pay. That goal is an unobtainable one and physicians are having to make life and death choices solely based on a patient's financial situation. Medical costs continue to skyrocket as the technology becomes more expensive, as the population ages and the baby-boomers become the elderly-boomers, as AIDS makes a continuing greater impact on the health care system, just to name a few of the fuels burning the "House of Medicine" down. In all of this the emergency department is caught in the middle as the means of easiest access to health care without regard to payment. I feel that some consideration needs to be given to emergency medicine as it occupies such a unique niche in the health care system. Protection from the increasing costs of malpractice insurance, except in cases of overt malfeasance, needs to be addressed at a Federal level and not merely left to the States. I would like to see fewer Stealth bombers and some sort of indigent trust fund to help defray some of the costs of emergency and trauma care. I would like to see more attention paid to preventive medicine so that people would not have to use the emergency department for general medical care. Finally, I would like to thank you for the opportunity to express my opinions in this overly long letter.

Sincerely,

Bradford L. [illegible], MD, FACEP

Bradford L. Walters, M.D., F.A.C.E.P.
Department of Emergency Medicine

Assistant Clinical Professor of Medicine
Michigan State University
College of Human Medicine &
College of Osteopathic Medicine
East Lansing, Michigan

WRITTEN TESTIMONY ON HIGH COSTS OF MEDICAL CARE

Catastropic Illness of Clifford W. Culham, Jr. (from 1/86 to 12/87)
Farmington Hills MI

My husband Clifford W. Culham, Jr., died on Decmeber 18, 1987. Cliff was a victim of Amyotropic Lateral Sclerosis (commonly called Lou Gehrig Disease). Cliff was placed on life sustaining equipment in April 1986. He contacted the disease in 1978 and was diagnosed in 1983. At the time of his death, he was 57½ years of age. ALS usually hits men/women in their middle forties. I'm appending a copy of an article written by Kate Stout of **McCall's Magazine** - which appeared in the September 1988 issue. It gives details of the struggle my dear husband endured, along with the members of our family as we tried to survive psychologically and financially in order to afford Cliff's care at home since we could find no facility in Michigan which was not private pay at $300.00 per day for special care units for ventilator patients. We lived through an 18 month nightmare and finally after petitioning the Oakland County Court, were granted removal of Cliff's life sustaining equipment. We were caught in a "catch 22" since our legal drawn "living will" and "medical power of attorney" were not legal in this State of Michigan. The hospital refused to let Cliff die and placed him on a life support breathing and feeding system.

Cliff's case was unique in that he was living through artificial and mechanical devices prolonging his life. But there are many citizens with such diseases as Alzheimer's Disease, stroke victims, etc., that have the same dilemma to deal with - no place to put the patient for care and no financial assistance to the family. Many diseases do not kill immediately but slowly do the patient in with little hope that there will ever be a full recovery. Prolonging the life of incurable wretchedness turns society and the standards of American medicine upside down - along with the families of such patients.

I've spoken across this great State of Michigan since Cliff's death in support of House Bill 4647 H-1 to find that most people are very supportive of letting an individual make the choice of life or death. My family knows first hand about the psychological trauma of keeping a loved one alive through mechanical life support, at great cost in both money and suffering not only to the patient but the patient's loved ones.

Modern medicine has created a sophisticated monster. There are many, many stories. My family's story is just one of them.

Once a patient is placed on life support, it is difficult to make the decision to withdraw it even though there is no theoretical difference between withholding and withdrawing. You do everything you can. The medical field - through know-how and sophisticated technology - can now sustain the physical life of patients beyond any reasonable quality of life they might want to endure. Ironically, while hospitals were once feared as "places to die", because so little could be done to avert death, some people now fear hospitals as placed to die because so much can be done to keep you alive - but not ensure recovery.

There are four modern techniques being offered that are enabling doctors to prolong death: (1) Cardiopulmonary resusitation; (2) Mechanical Ventilation; (3) Renal Dialysis; (4) Artificial Feeding. All four can keep you alive - but not ensure recovery since they cannot cure an illness. They are, to varying degrees, costly and unpleasant and even painful to endure. Most paatients using life sustaining techniques require 24 hour care and increase concern of physical and financial capabilities.

Meanwhile, a crisis persists for families faced with difficult legal and ethical problems created by life or death decisions made, not by nature of God, but in an ICU by a harried medical team. It does not take a Wall Street Whiz kid to figure out that a respirator dependent patient costing $300 a day in a special unit (outside of hospital setting) and are truly catastropic in both the medical and moral sense, to say nothing of the physical and mental suffering of the patient, the anguish of the loved ones at the bedside and the sometimes financially devastating costs.

With the cries of anguish coming from families and patients dealing with catastrophic illnesses, public opinion is beginning to solidify. While the sentiments concerning euthanasia or intentially ending life are well defined, the issues of withholding or withdrawing life-prolonging treatment are less clear. The real issue now is: Do individuals have the right to make their own health care decisions? And the consensus: Yes, it's a matter of choice.

There is a changing attitude toward what constitutes living and death. Many individuals as well as organizations have joined together endeavoring to convince the medical profession, the courts, and lawmakers that we as human beings have the right to make our own decisions about withholding and withdrawing life support. Along this line we also have the right to direct how our money is spent -- especially when these sophisticated life prolonging devices rob our families of their life savings -- even though a family may think they have ample insurance coverage.

My family, for example, not only suffered the trauma of handling the disease - we had to deal with the financial aspect and legal aspect -- which meant we were trying to survive in three different arenas. Our home was sold in order to have money to provide Cliff with the nursing and in-home care needed. As a working person, I had supposedly the best Blue Cross/Shield hospitalization coverage. However, policies do not cover durable medical equipment, nursing home care, aides and/or nursing care. Cliff's nursing care and rental of life support equipment (my portion after insurance paid 90%) ran me an estimated $3,500 per month. This was not 24-hour nursing care. An aide cared for him during my working hours - and I personally cared for him when returning home from work and every weekday night. I had total care for him on weekends - around the clock - unless I was so physically exhausted I could not function. Patients on life support must have 24 hour coverage. Especially with ALS patients who become totally paralyzed -- cannot speak, eat/swallow, move any part of their bodies, etc.

Until we have the backing of our lawmakers over issues affecting health care: 1)individual choice regarding life decisions and self-directed health care; 2)financial assistance in handling long term illnesses, this complex problem of how to care for critically and terminally ill loved ones, there will be no peace of mind for families handling such issues.

Thank you, Senator Riegle, for making health care issues a number one priority as you help to direct concerns at both the state and federal levels.

Joan B. Culham
62178-4 Ticonderoga Drive
South Lyon MI 48178

Phone: HOME: 313/437-8754
WORK: " 531-4060

June 28, 1989
Enc.

"I Want to Die"

The inspiring story of a courageous man and the brave and loving family that helped make his last wish come true

BY KATE STOUT

On December 18, 1987, Clifford Culham, 57, returned to his home in Farmington Hills, Michigan, to die. It was his choice, and it was supported by a court order, a compassionate physician, a devoted family and his own indomitable will.

For nearly a decade, life for Cliff had been a losing battle against advanced amyotrophic lateral sclerosis (ALS), a relentless killer that causes the body's nerves and muscles to degenerate. He was a prisoner of an almost functionless body, dependent on a ventilator for each breath and on an abdominal feeding tube for nourishment. All he had left was limited motion in his right index finger, the ability to move his head and, almost ironically, the ability to smile. The only thing that ALS—also called Lou Gehrig's disease, after the baseball legend who died of it at the age of 37—had not affected was Cliff's mind. It had been one year since he decided he preferred death to continued suffering, and he used this last resource to pursue that aim vigorously. On December 15, just three days before his homecoming, Cliff learned his wish had been granted: A Pontiac, Michigan, circuit court decision granted him the right to terminate his own life support. He was the first person in Michigan, acting on his own behalf, to win such a ruling.

Cliff and Joan Culham in 1980

In 1986 Cliff and grandchild Marissa can smile despite his ventilator.

Fighting for your own death takes a special kind of courage, and Cliff Culham had always been a man of exceptional inner strength and integrity. The oldest of three children and the only son, he was born in a sleepy small town on the outskirts of Detroit and was raised on solid values and a respect for hard work. He grew up to be a good-looking six footer, with blue-green eyes, light-brown hair and a wide, infectious smile. After serving as a paratrooper in the Korean War, he was setting himself up in what was to be his life's work as a carpenter and housebuilder when he met Joan, a stewardess for TWA. She was a petite, perky brunette whose positive manner matched his own unflagging optimism. They were married in 1957, and enjoyed one of those rare unions—they were good friends, good companions, so close they could almost read each other's minds. This last gift turned out to serve them well when Cliff had only his eyes and limited facial expressions left with which to communicate.

The first indications of ALS—some weakness in his left arm and an annoying facial tic—appeared in 1978 and did not, in themselves, seem like anything to worry about. In less than a year, however, by the time the Culhams' daughter Cindy was married, it was "a little bit evident on his face," his wife Joan remembers. "His smile—there was a little droop on one side. And he became tired easily." Most people, even those who knew him well, did not notice the change. But by the time Mindy, the Culhams' younger daughter, was married in 1981, the downward

(please turn to page 106)

"I Want to Die"

continued from page 105

tug on the right side of his face was quite pronounced.

In search of an explanation, Cliff went to the Neurology Department of Henry Ford Hospital in Detroit. Doctors found nothing wrong, but Cliff's relief was short-lived—within two years the ALS had moved into his left hand, causing tingling and numbness. This time doctors diagnosed carpal tunnel syndrome, a benign nerve disorder of the hands. He was referred to another neurologist.

That doctor did more tests. Then in January, 1983, as Cliff and Joan waited in the doctor's office to hear the test results, Cliff looked over at his wife and said, "Joan, I have Lou Gehrig's disease." An avid sports fan, Cliff knew about the terrible illness that had killed Gehrig, one of his favorite baseball players.

"Cliff, that's so pessimistic! That's not like you," Joan remembers scolding him. "You do *not* have Lou Gehrig's disease!"

"Joanie," he said quietly but firmly, "I have it. We'll have to deal with it."

When the doctor confirmed that ALS had been identified, Cliff was ready for the news, but Joan was devastated. The doctor gently explained what Cliff already knew: ALS often begins with muscle twinges and limb weakness; over time the weakness becomes total paralysis. Eventually all bodily functions are lost, including the ability to speak, swallow and breathe; a ventilator, a machine that forces air through a hole in the throat and into the lungs, is needed to keep the patient alive. There is no known cause or cure.

The doctor's words, "total paralysis" and "no cure," were too much for Joan, and she broke down sobbing. When they delivered the news to their daughters, there were more tears. Cindy, a nurse, knew all too well what the diagnosis meant. But his family responded by drawing on their natural closeness.

By the summer of 1985, Cliff could still walk but required leg braces and, occasionally, a wheelchair. Sometimes, as a new part of his body began to wither, he experienced terrible pain.

Still, Cliff persevered. When he could no longer build houses, he acted as a consultant. Later, he retrained and went to work on a computer in a friend's shop. He worked there for a year, four hours a day, four or five times a week. "He never gave up and he never complained," Joan recalls. Nor did he lose his sense of humor, despite his worsening condition and the family's financial concerns.

"I was constantly worried about money," Joan says. "All we had was thirty thousand dollars in savings and our home. I talked to Cliff about selling the house, because I thought it would give me a good cushion."

In September, 1985, they sold the home they had moved into as newlyweds 33 years before, and settled into an apartment in Farmington, a nearby Detroit suburb.

Preparations to sell the house raised a thorny issue—because of the ALS, Cliff was losing the ability to sign his name. Joan immediately recognized the consequences of this new problem. They retained a lawyer and had him draw up a Durable Power of Attorney, a document that authorized Joan to "speak" for her husband if he became incapacitated.

At Cliff's insistence, the document he signed on October 17, 1985, also contained his Living Will. A Living Will establishes in advance an individual's wishes concerning artificial life support. Even in states like Michigan, where there is no legislation to make them legally binding, Living Wills *do* serve to establish a person's wishes. Cliff specifically stated in his Durable Power of Attorney that artificial life support was abhorrent to him and that he did not want machines used to prolong his life.

That December, Cliff's breathing began to become labored—the first sign that the disease was spreading to his lungs. By January, 1986, "we could see the deterioration in him on a daily basis," Joan says. March brought the first life-threatening crisis when Cliff suddenly found it very difficult to breathe. Terrified, he made an emergency appointment with Mark Glasberg, M.D., director of neuromuscular diseases at Henry Ford Hospital and his physician since he was diagnosed with ALS.

Dr. Glasberg confirmed that the ALS had spread to Cliff's lungs, and counseled him to think about going on a ventilator at night. The doctor explained that many ALS patients require the ventilator only when they sleep and said it would probably extend Cliff's life by two years. In spite of Cliff's clear desire to avoid artificial life support, what Dr. Glasberg proposed did not seem that bad. If the ventilator would be required only at night, he wouldn't be totally dependent on a machine. Cliff decided to try it, but five days before the necessary tracheostomy was to be performed, he stopped breathing entirely. Joan rushed him to the hospital, where, in emergency surgery, a hole was cut in his throat and the ventilator tube was inserted.

The surgery was more than Cliff's already ALS-weakened muscles could endure. The ventilator was to become permanent; Cliff would never again breathe on his own. In a short time his ability to swallow also failed, and a feeding tube was placed in his abdomen.

"I was frightened out of my wits," Joan says. "I couldn't imagine dealing with the ventilator, plus working, plus the cost, plus everything."

For his part, Cliff was painfully aware of what an enormous burden on his family he was going to be, and he began encouraging them to place him in a nursing home. Neither Joan nor his two daughters wanted to do this, but Joan did agree to make inquiries about long-term facilities equipped to handle ALS patients. The decision, it turned out, was made for them: The only facilities cost $300 a day—far too much for the family's already stretched budget.

Six weeks after the surgery, Cliff was sent home. Joan continued to work at her job as an administrative assistant at the Methodist Children's Home Society in Detroit, caring for her husband every night and around the clock on weekends. She could afford help only from eight A.M. to four P.M., when she was at work (the Culhams' medical insurance did not cover home care). Joan learned how to suction the ventilator and clean the opening in her husband's throat. An alarm bell would go off whenever Cliff had a problem breathing. At night, it would ring about every two hours.

"I was so worn out," Joan says. "I'd go to work, close the door, put my head on the desk and sleep for two or three hours. Sometimes I'd think, I can't do this one more day."

By the end of the summer, Cliff could no longer walk. He had long since stopped working and spent his time watching television or being taken for walks in his wheelchair. The ventilator had to go with him everywhere. More and more, though, he had to stay at home with someone close at hand.

In December of that year, after he was hospitalized for one of the many respiratory infections that plagued him since going on the ventilator, he reached the turning point: He told Joan that he wanted the ventilator removed. From the beginning he had hated it. The area around the tracheostomy was foul—though Joan cleaned it every two hours, drainage still collected in the tube at the opening to his throat. It smelled terrible and left Cliff with awful taste in his mouth. The tube dragged at his neck. Worst of all was the knowledge that he could never get away from any of this.

"From the moment he went on the ventilator, life became terrible for Cliff," Joan says.

Dr. Glasberg was prepared to honor Cliff's wish to die, but the hospital refused to allow him to help. Administrators contended that even as an outpatient, Cliff was still part of the hospital system and that the hospital might therefore be liable if criminal charges were brought. Cliff wanted Dr. Glasberg to be fully protected. To achieve this, a court order allowing the termination of life support and providing the doctor with immunity from prosecution was necessary.

continued

"I Want to Die"

continued

Even though Cliff had established in writing his wish not to be sustained on artificial life support, it was not easy to find a lawyer to represent him in such a suit. Eventually, David McCleary, a conscientious and issues-oriented lawyer, agreed to represent Cliff.

"I felt very strongly about this case," McCleary says. "I thought it was an important issue. When I first met Cliff, I knew right off the bat this was what he wanted. It wasn't as if Cliff wanted to die. It was as if Cliff was tired of suffering and he wanted *that* to end."

Meanwhile, the medical bills of $3,800 a month (*after* what the insurance paid) were overpowering the family's resources. All but $2,000 of their life savings and all of the $67,000 from the sale of the house was gone. In addition, Joan could no longer physically manage her husband; he was too heavy for her to move or bathe or assist with a bedpan. So, in March, 1987, the Culhams moved in with Mindy and her family.

"Cliff's spirits were terrible," Joan recalls. "He felt it was a terrible thing to do to his children. But thank God we had them when we needed them."

Then, in autumn, the Culhams learned of a nursing home with an ALS facility in Bluffton, Ohio, ten miles from where Cindy had recently moved, but a two-and-a-half-hour drive for Joan. Cliff went there in September, the same month he became eligible for Medicare.

By November, McCleary was ready for the first of two hearings before Circuit Court Judge David F. Breck in Pontiac. Breck was known to be conservative. Unwilling to take anything for granted, he visited Cliff himself in early December. "My immediate concern was whether he knew what he was doing," Breck says. "I could tell from the very first question I asked that he was competent."

Basing his decision on his visit with Cliff, on similar decisions in other states and on the testimony of an expert in medical ethics, Breck granted Cliff permission to end artificial life support. In his December 15 opinion he wrote, "Following a patient's wishes in a case like Mr. Culham's is the equivalent of allowing the disease process to take its natural course." Breck would later refer to this as the "most meaningful case I've had in ten years as a judge."

On the day of his homecoming, Cliff weighed only 110 pounds. It had been one and a half years since he had been able to walk, talk, swallow, switch on a TV or turn the pages of a book. He could communicate only with his eyes and some facial movement. His vision was beginning to fail. Yet Cliff never stopped smiling.

"When they wheeled him in on the day he came home to die," Joan recalls, "I thought my knees were going to buckle. But he was smiling. 'Oh, my dear husband, you are glad to be home even under these circumstances,' I said."

Cliff's room in his daughter's house was just the way he had left it, except that now there was a Douglas fir—the Culhams' traditional holiday tree—decorated for Christmas. A few red poinsettias around the room brought the holiday spirit closer.

For a while Joan, Mindy, Cindy and Cliff's two younger sisters—as well as the family's physician, the family's minister and Dr. Glasberg—alternated small talk with words of encouragement. Each told Cliff it was not too late to change his mind. He never wavered.

There was even laughter when Cliff indicated he wanted to see old BJ the Cat and when he predicted that Mindy, who was pregnant, would have a girl. It was just at that moment, when they were joking about the baby, that an almost imperceptible movement in his little finger gave the signal. "I asked him if he was ready," Joan says, "and he nodded."

Dr. Glasberg began administering morphine and Valium through an I.V. drip—the two drugs would work together to calm and sedate him and spare him the panic of gasping for breath as the ventilator was gradually shut down. Before the drugs took effect, Cliff indicated his last wishes. He wanted a Douglas fir planted in his memory outside the window of the ALS wing at the Ohio nursing home and asked that it be decorated every Christmas. He reiterated his wish that his body be donated to ALS research. And he asked Joan, by mouthing the words, to "thank the judge."

Each family member had a special moment with Cliff, kissing him good-bye. To each, he mouthed "I love you."

Cliff remained alert for the first half hour. But even as the drugs began to take over, his eyes would pop open from time to time. Finally, Joan said to him tenderly, "You're taking one more look at your family, aren't you?" Cliff nodded and began to cry. He never opened his eyes again. About ten minutes later, he was dead of respiratory failure.

"It wasn't sad," Joan says now. "He was very comfortable, and his death was very humane, although it was hard on us watching."

To Cliff Culham, however, after nearly a decade of progressive physical deterioration and 18 months spent tethered to machines, the most important thing was, as Judge Breck wrote, "being released from his misery, no longer a captive to modern medical technology." ■

The Right-to-Die Controversy

Clifford Culham is one of very few people to have fought for—and won—the right to have his own artificial life support terminated. Most right-to-die cases before the courts are brought by families on behalf of someone unable to speak for himself. For example, the parents of Karen Ann Quinlan set a national precedent in 1976 when they won the right to disconnect their comatose daughter from a ventilator. (Quinlan, however, was to live nine more years in what is called a "permanent vegetative state," sustained only by a nasogastric feeding tube.) In either kind of case, however, the matter boils down to the same essential point: whether an irreversibly ill individual should be allowed to forgo medical treatment—even when the alternative is death. Some doctors argue that they are healers, not executioners, and refuse to discontinue treatment. Those on the other side of the issue argue that the patient has a right to self-determination.

In addition, a kind of controversy within a controversy rages about what exactly constitutes artificial life support. While the ventilator is universally accepted as an artificial life-prolonging instrument, another medical tool, the nasogastric feeding tube, whether inserted through the nose or directly into the stomach, is the subject of highly emotional arguments. For patients unable to swallow on their own, the tube is the only means of obtaining nutrition. Proponents of right to life believe that food and water are basic human needs and, no matter how they are administered, should never be considered "artificial"; hence, they should never be withdrawn. Proponents of the right to die argue that nutrients administered to patients in liquid form by tubes into the stomach are not natural and only prolong biological life indefinitely, as in the case of Karen Ann Quinlan

Several courts, however, have ruled in favor of withdrawing nasogastric tubes. In 1986, Elizabeth Bouvia, who suffered from severe cerebral palsy, won her bid in California to forgo further nasogastric feeding. The court ruled that it was not a legal or medical decision but "a moral and philosophical decision that belongs to the patient alone as a competent adult."

No matter what the courts may decide, this is not the kind of problem for which a solution satisfactory to everyone will ever be established. The only answer lies in communicating your own personal feelings on life support to your family and friends, preferably in writing and ideally in the form of a Living Will. If there were no hope of recovery, would you want to be sustained by a ventilator? Or a feeding tube? Tell the people closest to you what your wishes are and *write them down*. Then, in the event of a tragedy, even if you are in a coma, you can still speak for yourself.

For more information on Living Wills write: Concern for Dying, 250 West 57th Street, New York, NY 10107.

Rose Curley
37757 Wabash
Romulus, Mich. 48174

To whom it may concern,

My name is Rose Curley, I have an eleven year old daughter and a twelve year old son. I am thirty five, Currently going to college and I'm a widow. My husband died almost five years ago.

In the last five years I have realized how hard it is to raise a family without health insurance. My children and I receive about 17,000 dollars a year from the government. I am very happy that we receive this money but in the process of receiving the money from the government, to my knowledge we are not allowed any state funded medicaid, we're not entitled to medicare which is provided by the government to some people and I can not afford blue cross or any of the high cost insurance that is offered.

It is very hard to survive without health insurance. I no longer go to the doctor for a physical or routine check ups. I can't have my eyes examined anymore either can I afford the high cost of a dentist. My son's glasses were broken on the school bus and I'm trying to save the money to get new glasses for him. Two months ago he broke his arm and I owe around 2,000 dollars or more on that hospital bill.

It seems to me that when a person doesn't have insurance, the health professionals charge the same amount that they would charge any insurance company. With the high cost of medical treatment, without insurance, its almost impossible to go to a doctor knowing you may starve to death because you went.

I feel that my children and I live on a line, so to speak, because I know if one of us were seriously injured or became very ill we would lose everything we have. I always live in fear just trying to make it from one day to the next hoping that we stay healthy. For me and my children, not having any kind of health insurance has been terrible.

I hope and pray that the state or the government or someone realizes that just because widows and children get their money from the government ~~doest~~ doesn't mean that they don't get injured or sick. In the past five years I have often thought that widows are discriminated against, because health is something money cannot buy, so which is more important the health insurance or money that we receive?

Hopefully, in the near future something will be worked out so that everyone has health insurance.

Thank you
Rose M. Curley

June 19 1989

Dear Senator,

Regarding Health Hearing on June 28 1989. I feel I should tell my views. I am a young man in my 20s and I have Cerebral Palsy which Ive had seen birth.

For years I never had a problem with health Care Until I was on my own. As I was covered by my Parents health Plan. After I became a Adult I was no longer aloud on plan.

Then I was receiving Social Security Disability. And I was on a Blue Cross Blue Shield Plan Until it was to costly to keep. As I checked for other reasonable insurance I found that none of them reasonable and good coverage policy

P 2

Had small print stating
I OK.ed for Medicare
you could not get
the Policy which is CRAZY
because if I could the
cost would be cheaper
for me as well as
the government. But I
found out that if you
don't pick up Medicare A-B
with able cost goes up
automatically 10% each
year you wait. and all
that is is another
DUMB LAW!
If they made it EASIER
for all people to get
coverage throu All Companies
there Wouldn't be a
problem because it would
balance out because of
all other Insurances
premiums would be
afordable and coverage
would be good.

P3

Why is that so hard it make scent and solvent the problem for us.

It would take problems away from old and the Medican System.

I am Handicapped YES but I am Healthly some are more then other but we help each other, because we all dont need help all the time we do live nomal lives just like you and not living one minute in a Doctors office and next in the hosiptial.

We eat, sleep, work, and play just like you.

We are humans and not just problems.

As for care day after day I myself havent been to a Doctor ~~in~~ 11 years for C. P. sounds like a real ~~Bad~~ Medical Illness [illegible]!

P 4

It cost are high
how about giving more
money in a SSI check
to cover expenses..
Congress thinks $20.00 a
month increase in check
per year will take care
of everything Doctor, pills
out of pocket cost
I know put Congress
Health Plan on Medicare
and see how they like
it.

It is tough enough
for disabity people to
survive let alone having
to worry about Medical
Care in the U.S.A..
Please I ask for
not just me but
every Amicara that
has this TOUBLE!

Sincerly,
Larry E Demarest

June 26, 1989

Senator Donald W. Riegle, Jr.
705 Washington Square Building
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

I support the mission of the Coalition for Access to Health Care, of which I am a member. We are dedicated to access to comprehensive, necessary, quality health care services for all Michigan citizens. These services should also be affordable, cost-efficient, and provided in an appropriate environment without regard to any pre-existing medical condition. It is my **personal** hope that such access would be available to persons across the country, not only to people in Michigan.

To achieve such universal access, a number of issues require thoughtful analysis and solutions which are widely applicable.

First, it is a travesty that so many individuals are employed in low wage, relatively dead end jobs, without health and dental insurance. It seems to be America's attitude that "someone has to do the glut work". Often, when such insurance is made available to these employees, a disproportionate share of their paycheck is required to obtain coverage. Many people opt not to buy into these plans because they are simply unaffordable to persons earning small incomes.

The Medicaid system is flawed in many ways, but it is still preferable to having no insurance at all. Increased income limits and opportunities to buy into the plan may serve to lessen the pool of persons without insurance--which is of particular importance to families with children. Also, I view coverage as a right--not a privilege--yet, we have no other rights in America which require impoverishment of the individual to achieve them.

Persons who have recently become unemployed sometimes are offered continuation and conversion options when their relationship with an employer is severed. These generally are quire costly and payment is required soon after the separation--during a period when the persons may have little spare money. If the person is relying upon unemployment insurance administered through MESC, the buy-in window (generally 30 days) may well have elapsed before the person has received any cash to pay for the coverage. Statistics I have uncovered demonstrate that infants, the elderly, and women of child bearing age pay more than other groups for coverage, because of the relative health care costs associated with persons of each group. While I appreciate the insurance industry's rationale, I resent the implication that persons like myself, who haven't yet borne children, are essentially subsidizing other women who choose to do so!

Decisions made about which items to be covered seem capricious. For example, substance abuse and prosthetics for mastectomies are covered, as mandated by Michigan law. The "basics", like hospital and surgical care are not required to be covered. Prescriptions, which are often used in a preventive manner, are sometimes only partially covered. I wonder about the "abuse" among persons who do have insurance coverage and purchase prescription drugs at the expense of everyone in the insurance pool, only to stop taking the drugs after a couple of times. I also wonder how many prescription drugs are truly necessary. And, what could Blue Cross/Blue Shield's logic have been when they decided to cover abortions but **not** birth control pills? The lack of information sharing between the automobile and health insurance industries is similarly puzzling. I wonder why these two groups can't agree to each pay half of their client's medical claims, or organize a similar mechanism where the individual policy holder is neither over nor under compensated for their medical expenses.

The difficult-to-insure population faces primarily a financial barrier. With BC/BS being Michigan's mandated insurer of last resort, and although persons can obtain non-group medical coverage regardless of medical condition, with a premium ranging from $1500-$4100 a year, many of the high medical risk population can ill afford such premiums when their needs have increased and their income may well have dropped. Risk pools are threatening because they often result in essentially legal discrimination against persons with disabilities. The higher premiums, items which are necessary but not covered (such as durable medical equipment), and the lifetime benefit limits are all serious drawbacks to the formulation of risk pools.

Catastrophic illness and long-term care policies often do little more than scare the people who buy them. The insurance policies are difficult to decode, the language is terribly confusing, and people often don't know **what** they're covered for until they face an expensive and life-threatening incident. Coverage which is contingent upon going right from a hospital into a nursing home is lacking; research has shown that the average probability of **not** collecting benefits is 61%, primarily because of various non-understandable clauses in the policies. Fear of Alzheimer's disease has caused a number of persons to purchase such insurance, with little "proof in the pudding" to date of what will and won't be covered.

The impact of chronic illness on the family ecosystem has a particular impact on the stress level of the family, particularly when it is unpredictable and uncontrollable. The time and energy demands upon the family can't be determined on any economic scale, yet we are seemingly moving toward a system where the family is the caregiver of first, and often, only resort. Flexible family roles, greater cooperation by employers, strong social supports, and a better understanding of the implications of chronic illness are necessary in American society.

I support an Americanized version of the Canadian health care system and strongly advocate for an adaptation of Perry Bullard's Michicare plan. Employers must be more responsible and less enmeshed with their bottom line; the nation on the whole must take a more proactive and better educated approach to solving the problems of access to health care. Also, health care must be far more proportionate to the costs of other services in America. The publication Closing the Gap, by Robert W. Amler and H. Bruce Dull points to the lack of consideration for the linkage between preventive care, long-term savings and taking relatively simple steps (wearing seat belts, continuing with prescribed medications) to close the gap between illness, suffering, disability and wellness, resulting in markedly improved quality of life. Such measures are directly linked to long-term care, finance, and insurance implications. Whether or not persons have insurance coverage, the practices learned in childhood are important antecedents to adult disease or hopefully, wellness. Insurance providers need to consider the very far reaching and long-term effects which are being made today so all of us, adults and children alike, can benefit from their informed decisions.

Thank you for this opportunity to share my ideas on access to health care. There are many ideas to consider, and I know these only touch the tip of the iceberg. If you would like the sources of where I found these statistics, please call. I look forward to seeing excellent outcomes from this hearing.

Sincerely yours,

Jacklin K. David

Jacklin K. David, MA, MS
1556 Cambria Drive
East Lansing, MI 48823

Staff Assistant, MDPH
Chronic Disease Advisory Committee

Home: 517/337-7438
Bus: 517/335-8403

June 26, 1989

Dear Honorable Donald Riegle:

I would like to express my views on the health care issue!

I am currently a Chrysler-UAW autoworker. My current health care coverage is the envy of my retired parents and most other senior citizens, who must pay for their own. I know the feeling they have when they recieve their doctors bills and bills from the 'Blues' and other providers, for I was unemployed for two and a half years and paid those bills too.

I'm fortunate - for now. I'm not one of the 600 (plus) employees at Sterling Heights Assembly Plant, who are to be laid off next month because of slow car sales. Some will be eligible for a few months of extended coverage, but most will expire shortly after lay off.

Some people say I've got it made with my job and it's benefits - but as you can see - nothing lasts forever.

And you know, this really isn't the best job in the world and someday I'd like to leave and start a small business. But the idea of having to pay those huge individual health care premiums and possibly doctor bills, makes me feel imprisoned to this job.

As much as we hate the word TAX, myself and I believe most Americans, would be willing to pay our fair share to know we had health care available to us. They do it in Canada and other industrialized nations - it is long overdue in America!

Sincerely,
Carol S. Dawson

DAVID A DAWSON
4083 RIVERVIEW CIR
MOUNT CLEMENS MI 48043

①

6/26/89

THE HONORABLE
SENATOR
DONALD W. RIEGLE JR.

MY WIFE AND I WERE OUT OF TOWN AND DID NOT RETURN TO OUR HOME UNTIL THE AFTERNOON OF 6/24/89. IT WAS, THEN, WE LEARNED OF THE 6/28/89 CONFERENCE.

MY WIFE AND I DISAGREE WITH THE VERY LIMITED HEALTH CARE PROGRAMS (MEDICAID AND MEDICARE) NOW IN EFFECT. TO GET TOTAL COVERAGE, SENIOR CITIZENS NEED

- MEDICARE A & B
- BACK UP COVERAGE
- LONG TERM SUPPLEMENTAL COVERAGE
- NURSING HOME COVERAGE.

BASED ON THE SENIORS WHO WILL PAY NOTHING OR VERY LITTLE CATASTROPHIC TAXES, AT LEAST 85%(AND PROBABLY 90% PLUS CANNOT AFFORD THE COVERAGES LISTED ABOVE.

WE BELIEVE THE U.S. GOVERNMENT MUST ESTABLISH A TOTAL HEALTH CARE PROGRAM FOR ALL OF ITS CITIZENS.

2

THE LETTER ENCLOSED IS FOR PUBLIC KNOWLEDGE.

- YOU MAY READ IT HERE
- YOU MAY READ IT IN THE SENATE & HOUSE CHAMBERS IN CONGRESS.

EACH AMERICAN CITIZEN IS ENTITLED TO PROPER HEALTH CARE. VERY FEW CAN AFFORD THE PRESENT PROGRAMS, AND WORSE YET, FEW, UNDERSTAND THEM.

RESPECTFULLY,

E. K. Dayton

EUGENE K DAYTON
15420 BLUE SKIES CT E
LIVONIA MI 48154-1507

6/25/89

Health Care For Citizens Of The United States

The political leaders of this country should be ashamed of themselves. They have created thoroughly confusing, very limited health care programs that practically none of the people of the United States, regardless of age, understand.

Most citizens do not know the difference between Medicaid and Medicare, nor do they understand the details of the myriad "secondary and supplemental health insurance plans" that are pushed at them by the insurance industry to cover services, supposedly not covered by Medicare. Many, further, do not know that long term nursing home care is not normally available in said "back up or secondary programs", but rather, must be purchased separately, at an additional cost. Most citizens can not afford all of these costs. These patchwork, partial health care programs are not doing the job and need to be replaced by a National Health Care Program, managed by the Federal Government.

What we citizens need is a total health care program, covering each of us from birth, to and including a simple, no frills, burial. Said program should cover all medical, dental,/eyeglass, etc., care; all doctor, dentist, ophthalmologist, nursing, etc., care; all prescription and health aid, etc., care and a simple burial for each citizen, who desires said burial.

The program should cover all normal health needs but should not include very expensive transplant operations. It also should not include such frills as face lifts, fat removal, etc.

There should be no direct expense to any individual; for any such health service. Such a program may be funded by a value added tax on all goods manufactured in the United States, the same tax on all imported goods, a tax on all U.S. individual tax payers and a tax on all businesses, which would, then, be able to discontinue their own health care programs.

All U.S. citizens twenty one years of age and older, who do not pay federal taxes should be required to provide free work to the U.S. Government, to pay their fair share of said health care program, unless they are excused, for reasons of health, from said work, by doctors appointed by the U.S. Government.

All funds accumulated for such a National Health Care Program are to be maintained separately, from all other U.S. Treasury funds. They are to be invested wisely and all such funds, principAL and interest, are to be maintained by and used exclusively for, the U.S. National Health Care Program. Said funds are not to be loaned to the U.S. Government, to hide the size of the budget deficit --- ala Social Security funds.

Practically every major country in the world has a national health care program for its citizens, except the United States.

It is time we stopped protecting and supporting the world and instead started to provide total health care services for all U.S. citizens. Such a national health care program would eliminate both Medicare (A & B) and Medicaid programs and their related taxes and costs.

Respectfully,

E K Dayton

E. K. Dayton

July 1, 1989

Dear Senator Riegle:
I am very sorry to have missed your meeting on Health that was held in Southfield on June 28, 1989. I did not get your letter until today.I am very interested because of the problems we have encountered with my Mother and her health problems in the last year.
In May of 1988, my mother was diagnosed to have Small Cell Carcenoma of the lung. My parents did not have any medical insurance at the time. We children did not know just how hard financially our parents were haveing it. We tried the State Agencies but got nowhere quick and the doctor did not want to wait to start treatment. Treatment was started at my parents expense the day after we found out about the cancer. We started trying to find some help that very day. The Social Services Dept. seemed to drag their feet until we finally contacted their U.S.Senator Strom Thurmond. After contacting his office and he contactong the D.S.S Office in Aiken, S. C. we finally got a letter saying the were waiving certain periods of time in order to speed up my mother getting on Medicaid.
In order for my Mother to qualify for the Mdeicaid she had to have In Home Health Care Services. Well to make a long story short they finally datermine that she would qualify and the Medicaid came through in September of 1988. It was retroactive to July 1,1988. We were very appreciative of the help on the medical bills. The D.S.S Office arranged to have someone from the In Home Health Services to come in and do light housekeeping chores 3 days a week. Last week my mother was informed that she no longer needed these services and that the Medicaid would be discontinued due th her no longer needing the In Home Services.
Senator Riegle ~~my~~ mother can do very little for herself. She is able to barely bathe and dress herself. When she does the personal needs she is exhausted. Between her & my Dad they manage to get enough food cooked to keep from goinh hungry. My Dad has health problems too. He has back problems and bad knees that make it hard for him to get up & down and around. My Dad is 65 and my Mom is 62. WE tried to get her disability through but she didn't have enough quarters paid. If they cut off the Medicaid my Mom will have no insurance of any kind as they can't afford it. As of right now tests indicate that my Mom is in remission from the cancer but that doesn't stop the tests she has to have periodically and also she has an abdominal aneruysm on the aorta artery. My parents just cannot make it on their social security checks which is under 800 dollars a month for both of them. Its not right to treat our senior citizens like this after they have worked hard all their lives and paid their taxes which support the systems of the State.

We Five children helped out our parents financially until we were about to go under financially. Not only must we worry about what is going to happen when the cancer comes back again but now my parents are worried about what is going to happen when my Mother needs more chemo or radiation therapy and there is no way they or we children can pay for it. Cancer therapy does not come cheap. It is very expensive and we are still paying off the medical bills that were incurred before the Medicaid took over last July.

We are all for any help you and your Committee can get for the uninsured citizens of thes great country. The system is so unfair. With the medical costs sky rocketing so many of our citizens must go without the proper medical insurance because the prices are so high and it is either buy food or starve and try to have insurance.

It is very frustrating to try and get any kind of Medicaid when you have serious illness in the family. Its frustrating to see people who are able to work and don't or won't get all the Medicaid they need and then when your family needs it to be denied or to be discontinued from the program when the medical need is still there. I know first hand the financial hardship of trying to pay for medical bills for a loved one. My family has nearly gone bankrupt trying to pay my Mothers bills before Medicaid. God only knows how much more we will have to pay if her Medicaid is cut off. How many families are in the same boat we are?

Just because the cancer is in remission that does not mean it will not return. This kind of cancer is known to spread to other organs. In any probability it will soon return. What do we do then? Our finances are drained and all our reserves gone. We can't say we can't afford for you to have this therapy because it is too expensive. So what are we the family to do?It is like banging your head into a stone wall for all the answers you get.

If your office has any idaes of what we can do to keep my Mother's Medicaid in effect would you or your office please contact me. We are at the end of our rope as far as having any ideas of where to get help. I realise my parents do not live in your State but in South Carolina but anything you could do or anyone you know who we could contact would be very greatly appreciated.

Sincerely,

Thelma L. De Angelis

Thelma L. De Angelis
25490 Fairgrove
Woodhaven, MI 48183

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Judith M. Desenberg, MA, MSW, CSW

Address 12879 Sherwood
Huntington Woods, 48070

Representing : myself - private contractor - clinical soc. work
Oakland Family Services, Berkley Mi

****

I invite you to attach a prepared statement or to submit your written testimony:

The uninsured, generally the poor of our population, who need mental health counseling possibly more than others are discriminated against in this area. Even public + non profit agencies must charge a fee that often is out of reach to these clients.

Please consider mental health insurance as well as ins. for physical ills.

*Also: in + out patient help, for uninsured substance abusers, is definitely out of reach to those without insurance -

Those who have health ins, are employed should perhaps pay more so all our people can get help so sorely needed + necessary

THE DETROIT MEDICAL CENTER
The Academic Health Center of Wayne State University

Subsidiaries

Children's Hospital
of Michigan

Detroit Receiving Hospital
and University Health Center

Harper-Grace Hospitals

Hutzel Hospital

Rehabilitation Institute, Inc.

DMC Coordinated
Health Care, Inc.

HealthSource

Radius Health Care
System, Inc.

Health System
Community Hospitals
- Huron Valley Hospital

The Detroit Medical Center

June 28, 1989

The Honorable Donald W. Riegle, Jr.
Chairman
Senate Finance Subcommittee on Health
for Families and the Uninsured
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

On behalf of The Detroit Medical Center, I am pleased to provide this written testimony for entry into the record for the hearing on "Health Care for the Uninsured," being held by the Senate Finance Subcommittee on Health for Families and the Uninsured on June 28, 1989 in Southfield, Michigan.

The Detroit Medical Center is the health care system affiliated with Wayne State University, and consists of seven hospitals serving southeastern Michigan. Our system is proud of our hospitals' long history of providing excellence in teaching, research, and a comprehensive range of health care services without regard to ability to pay.

But these long-standing missions and commitments to the people of Michigan are being threatened by our society's failure to adequately address the subject of this hearing - health care to the uninsured population in our community. For this reason, we are most pleased to see this subcommittee's interest.

It is estimated that there are approximately one million people in the State of Michigan who are without health care coverage from either private or public sources - more than 10 percent of the state's population. This does not include the population with inadequate insurance coverage. The lack of insurance coverage has two significant consequences:

continued. . . .

GOVERNMENTAL AND REGULATORY AFFAIRS • (517) 484-0711
215 S. WASHINGTON SQUARE, SUITE D, LANSING, MICHIGAN 48933

- From an individual standpoint, these individuals and families face barriers in access to care. It has been clearly demonstrated that the uninsured fail to receive preventive and primary care services, frequently resulting in unnecessary disability and illness, and delay of medical treatment until the need becomes emergent and more costly.

- From the perspective of a health care provider which renders a significant amount of care to the uninsured, the unreimbursed costs of that care present a serious threat to financial survival in today's competitive and cost-conscious health care environment.

The Detroit Medical Center is facing exactly these pressures today. We estimate that this year, 1989, our hospitals will provide uncompensated care in excess of $50 million to patients with no insurance and who do not qualify for any public health care program. Furthermore, this amount does not include the value of services provided by our physicians who render services to these patients. And this is despite the fact that Michigan's Medicaid program is one of the more generous programs in terms of population coverage.

We anticipate that the amount of uncompensated care will continue to climb in Michigan if no solutions are found. The increase will result of significant changes occurring in Michigan's economy from a predominantly manufacturing base (which has historically provided comprehensive health insurance coverage as a benefit of employment), to a service sector base (which is far less likely to offer health insurance).

The effect that this problem is having is marked. Health care institutions which never before have questioned their missions to care for the indigent are commonly having heated discussions about the potential need to limit their services to the uninsured. Nobody believes that this possibility is good for their communities, but it is a subject which cannot be ignored when the financial survival of the institution is threatened by it, thereby threatening the ability to serve the entire community.

We do not have the details of the solution to this troubling problem. Clearly many at the federal level, and in many state governments are studying ways to ease the problems of the uninsured. Your committee along with others in the Congress have succeeded in making incremental expansions of Medicaid and other programs in an attempt to "fill some of the gaps," and we applaud those efforts as good short-term changes.

But we believe that a broader, longer-term strategy is also needed, so that our society has a common direction toward which efforts can be aimed by the federal government, state and local governments and the private sector. In that light, we offer the following as general directions toward which we should be moving.

1. There now exists, and there will always exist, a need for a public program to provide coverage to those individuals and families with no source of private insurance through employment, nor the resources to obtain individual coverage. Today, that broad public program is Medicaid. However, Medicaid continues to be predicated on notions of "the deserving poor" through the establishment of categorical requirements for eligibility.

   We need to be forcefully moving toward a public program of health care financing based not on categorical eligibility requirements, but solely on resources. That is, persons with incomes below certain standards, should be automatically covered under a public program which provides at least basic health care benefits, regardless of age, disability, family structure, public assistance eligibility, etc.

   Congress has taken the first steps toward this concept of unlinking Medicaid coverage from public assistance eligibility through expansions for pregnant women and children based solely on income level.

2. Clearly two-thirds of the uninsured population are individuals who are employed or who are dependents of working people. Solving the problem of the uninsured will require a greater degree of responsibility by the employers of this country to provide health care coverage as an employee benefit. The only question is whether mandating coverage is necessary or whether the employers will respond to strong incentives to provide coverage. Some employers rightfully argue that the costs of coverage is too great - we believe that the costs of non-coverage is too great for those without benefits and for those health care providers who are struggling financially as a result.

3. The solutions to these two arms of the uninsured problem cannot be financed by further reducing payments to health care providers. Over the past several years, we in Michigan have seen expansions of coverage financed by the reduction in payment levels to hospitals and others rendering services. Over 70 percent of Michigan's hospitals are losing money on

the provision of patient care services - largely as a result of payment constraints implemented by the public sector payers - Medicare and Medicaid. We cannot withstand any further cutbacks.

4. Lastly, the national scope and consequences of this problem must be recognized in searching for solutions. A public program covering the low-income population must not continue to be financed the way Medicaid is. Every expansion of the Medicaid program sends our state budget reeling because of the large share of state funding required by the current match formula. Further, any mandates or incentives for employers is most appropriately accomplished at the national level, so that interstate business climate competition is not affected.

We appreciate the opportunity to offer these observations, and encourage the subcommittee to move forward on these difficult, but crucial challenges.

Sincerely,

Robert J Yellan

Robert J. Yellan
Vice President
Governmental and Regulatory Affairs

RJY:jmh

270 Waldon Rd.
Pontiac, Mi. 48057
June 29, 1989

Donald W. Riegle Jr.
Senate Finance Subcommittee on Health
St. Johns Armenian Church Cultural Hall
22001 Northwestern Highway
Southfield, Michigan

Dear Mr. Riegle,

My concern is the exsisting general health care. Enclosed are two(2) articles. One stemming from a dream, and the second article because of blood transfusions that prompt my interest in the blood groups.

After my husband had undergone six(6) months of chemotherapy, I asked his doctor to do another blood type identification to see if changes had occured in the blood groups. She agreed, but then the hospital lab refused to do the blood test. Later, on two occasions I had mine done. On one occasion the test was refused, and one said type O positive (meaning that there are blood groups, but the test was not done completely).

My question to you is: What is the difference whether a person has health insurance or not.

I think you would be doing a better service to society if it (people, like myself) were permitted to have records of their blood when it was healthy. Then it would be easier to detect when ill-begotten antibodies set in.

I will always wonder why the blood type identification test is ten 10 reasons refused.

Yours truly,

Rita Deuman

Rita Deuman

A Nightmare or A Reality?

At night dreams would appear, saying, "Remember." My thoughts would flash to when my husband had gallstones removed from his bladder.

Inside the dream, I could clearly see myself sitting in our family physician's office, asking the doctor, "If Bill had a liver problem before the surgery, would he still have the liver problem after?"

Dr. Spiering removed the fancy, carved, dark wooden pipe from between his teeth to answer. "Yes, probably so!"

The dream's sharp image drew my attention to a doctor's manila folder that sat on my lap. I opened the pages to find that the print was a blur. Yet, I forced my eyes to read through the smudge. I flipped to the last page where the words "Hodgkin's disease" were the only understandable ones.

In the twilight of my reverie, I dreamt that I returned home and walked across the street to my neighbor Mary's house Mary was a nurse, and I wanted to borrow her medical dictionary. Instead, she handed me a highly technical medical book that was written in layman's English. Each disease associated page was filled with detailed diagrams displaying malformations outside and inside the body. I read about the six subjects under the Pernicious Anemia caption: Leukemia, Sickle Cell Anemia, Hodgkin's Disease, etc. (Three diseases, I couldn't pronounce and didn't write down.) Two blood disease pages sat side by side. One was Hodgkin's and the other remains unknown. I pointed to the one page and said to Mary, "Bill has the Hodgkin's disease symptoms."

Mary pointed to the other page, commenting, "No, his symptoms match this disease much better."

My mouth dropped as I replied, "That disease sounds so terminal that they don't give any treatment for it. Yet, look at the diagram. It's written as if they documented the disease's advancement while watching the patient die. It sounds like an act against humanity!"

Four years later, reality was leaning in the direction of the dream. I called my neighbor to borrow her highly technical medical book. Mary stated that she did not own the literature written in layman's English filled with detailed diagrams.

In the flutter of confusion, Bill's neck lymph nodes had become grapefruit size, so he consulted a hematologist/oncologist. The hematologist would use Bill as her guinea pig, explaining to her trainees that "soft tumors" were always benign. At the same time, TV had a cancer series, talking about malignant "soft tumors".

Bill and I watched the situation from the patient's point of view. Therefore, we were not aware that many abnormal blood tests results were used as "markers" to aid in identifying cancerous conditions. Also that miracle drugs such as the antibiotic adriamycin were no longer administered until infections turned human tissue malignant.

After months of being treated for an autoimmune deficiency blood disorder, it was recommended that Bill have a modified radical neck surgery to biopsy the lymph node tissue. The hospital that recommended the biopsy done reported the tissue as Hodgkin's disease/mixed cellularity. A second hospital report was that the tissue was benign. Meanwhile, Bill had a hemolytic reaction and had to be transfused with a special blood type: A_2 DCcEe, +DAT, S-, s+, K+k+, Fy^a+, Fy^b+, Jk^a+,Jk^b+. At that time, the blood's incomplete (drug/disease) antibodies were labeled healthy and the blood warming caused the disease antibodies to disappear. Bill's disease remained labeled autoimmune deficiency.

Naturally the patient's illness dramatically worsened. The month after Bill's modified radical neck biopsy, an infection strong enough to disintegrate bones hit his back. The hematologist prescribed muscle relaxers. A month after they didn't work, she had Bill hospitalized for therapy. At the hospital, Bill had what appeared to be a compression facture with an infection disintegrating his spine, spots on his lungs, and enlarged lymph nodes under one arm. Therefore, a back surgery biopsy was recommended. Again the hematologist insisted that Bill's condition was not malignant, and I questioned that diagnosis. The hematologist/oncologist raised her arms and stretched them apart to show the mammoth improbability, stating: "For this to be Hodgkin's disease, Bill would have to have had so much chemotherapy and so much radiation that there's no way he could be in this shape with the treatments he's had."

If the disease was Hodgkin's, the patient was in the fourth stage and approximately one month from dying. So I went home and called the hospital that had recommended the first neck biopsy. I was informed that it was they who had diagnosed the tissue as Hodgkin's disease and that they were told that two other diagnosis were benign. They were not aware of any problems.

After the back surgery biopsy, Bill's treating hematologist began to explain her plan of medical action. She still didn't believe the condition was Hodgkin's and she wanted to run more test. I snapped my reply, "As far as I'm concerned, you lied to Bill. When he was given a choice of two hospitals, you said it didn't make any difference which one he went to. The other hospital would have begun treatment months ago, while staying with you means dying. You'll be running no more test. We'll be changing doctors and hospitals. But before we go, it would be best for the both of us, if a third opinion be called in."

Whenever a patient is presented with distressing cancer news, the hospital has a social worker assist the patient and spouse. I showed her the blood-type identification and asked, "What do each of these letters symbolize? I'm wondering if an infection is causing one of these antibodies? I realize that you may not know, but you would have an idea of who to ask."

The social worker felt that the blood-type identification was a legitimate question. She went into the pathologist office, then returned to me, saying, "I have just the man that you can speak with. If anyone can explain this blood-type, he can." The social worker showed me to his office door and left. I entered.

The head pathologist's office was neat and attractively arranged. His desk sat at the right with a large bookcase. A dark vinyl sofa was situated to the left of his desk. The sitting pathologist motioned for me to come in and have a seat on the sofa. He was an older man with a foreign accent. The pathologist placed his hand to his forehead, whisking away the few dark strands among the grey hair covering his temple. He moved his hand and pointed his fingers in my direction, saying, "There is nothing wrong with this blood-type. I would swear on my reputation as to the creditability of everyone who works under me in the lab. I know everyone here. I was one of the first people to walk into this hospital. I came into the building before it was built. Matter of fact, I think I was sitting right here in this chair and the walls went up around me. Y-e-e-s-s, I was he-r-e, sitting in this chair, in this very spot when the hospital was built." The pathologist changed the subject back to the blood-type identification. "I know all about this. I teach. I have students. There is nothing wrong here." He then placed his hand on the paper on which I had written my question.

I stood up and dashed to the pathologist's side. Looking over his shoulder and pointing to the paper, I uttered, "Good, tell me about these letters DCcEe."

The pathologist reached for a book on blood-type. Quickly he opened it to a page pertaining to the Rh system, saying, "They mean nothing."

It was hard for me to read a page of words in half-a-minute. My patiences ran thin, and I blurted, "You said you taught. So teach! Use the big words. They won't bite." I then pointed to the letter "D", asking, "That's the Duffy system isn't it?"

"No!" The pathologist shook his head, moving his finger to the Fy^a+, Fy^b+ and replying, "This one is the Duffy." He then moved his finger to the right and pointed to the Kidd system Jk^a+, Jk^b+ and continued, "I don't know what that one is." The pathologist's hand moved to the left across the list of antibodies, as if the only system he could recall was the Duffy and the Rh that he had just explained.

Thus I shrugged my shoulders and said, "I have to go. I'm supposed to be someplace else, making the ambulance arrangements."

Meanwhile, the hemotologist was telling her patient Bill good-bye, "Soon you'll be transferred to another hospital. When you get there, they will stab you full of needles and poke holes all over your body. But, in six months, you'll be alright.

The dream's only value is what it's worth to the one on whom its bestowed. While the patient lived and was sued for non-payment for the superior treatment above the insurance allowable allottment.

Blood Type Identification-
A Drug/Disease Indicator?

What is blood type identification?

The classification of blood samples according to their agglutination reactions with respect to one or more blood groups. Blood grouping is useful in genetic and anthropologic studies.

A blood type identification example:

BLOOD TYPE IDENTIFICATION

NAME William Deuman

BIRTHDATE 6/20/42 SEX M

BLOOD TYPE A_2 DCcEe

UNEXPECTED ANTIBODIES Warm Autoantibody

SRECIAL TYPE +DAT, S-, s+, K+k+ Fy^a+, Fy^b+, Jk^a+, Jk^b+

A - ABO blood group system.

DCcEe - Rh blood group

+DAT - A positive reaction to the Coombs' test. An 'incomplete' antibody also known as IgG.

S-s+ - MNSs blood group

K+k+ - Kell blood group

Fy + Fy + - Duffy blood group

Jk + Jk + - Kidd blood group

In 1939, the British Government's medical advisers realized that large numbers of blood transfusions would be needed throughout the Second World War. The ABO system (type A, type B, type AB, and type O) was the only known blood group system of clinical importance.

Before the war, a group had begun work on the genetics of the blood groups. The group was supported by the national Medical Research Council and included Dr. G.L. Taylor as director and Dr. R.R. Race. At the outbreak of the war, the group was instructed to move from Professor R.A. Fisher's Galton Laboratory at University College, London to the Department of Pathology of Cambridge University. The group became known as the Galton Laboratory Serum Unit.

In 1940, when the rhesus blood groups were discovered by Landsteiner and Wiener, and shown to be of clinical importance, the unit, and Dr. Race in particular, began to carry out fundamental work on the new system. The work (Race and Taylor, 1943) became the basis of Fisher's CDE hypothesis and notation of the immunology and genetics of the system. The first publication of these was by Race (1944). In the same paper Race also showed that, in addition to the supposedly normal form of Anti-Rh (henceforth to be known as anti-D) antibody, which agglutinated D-positive red cells directly, there existed a variant, known as 'incomplete' antibody. This could at first be detected only by the 'blocking test', the blocking of RH-positive cells which had been suspended in the incomplete serum, so that they become inagglutinable.

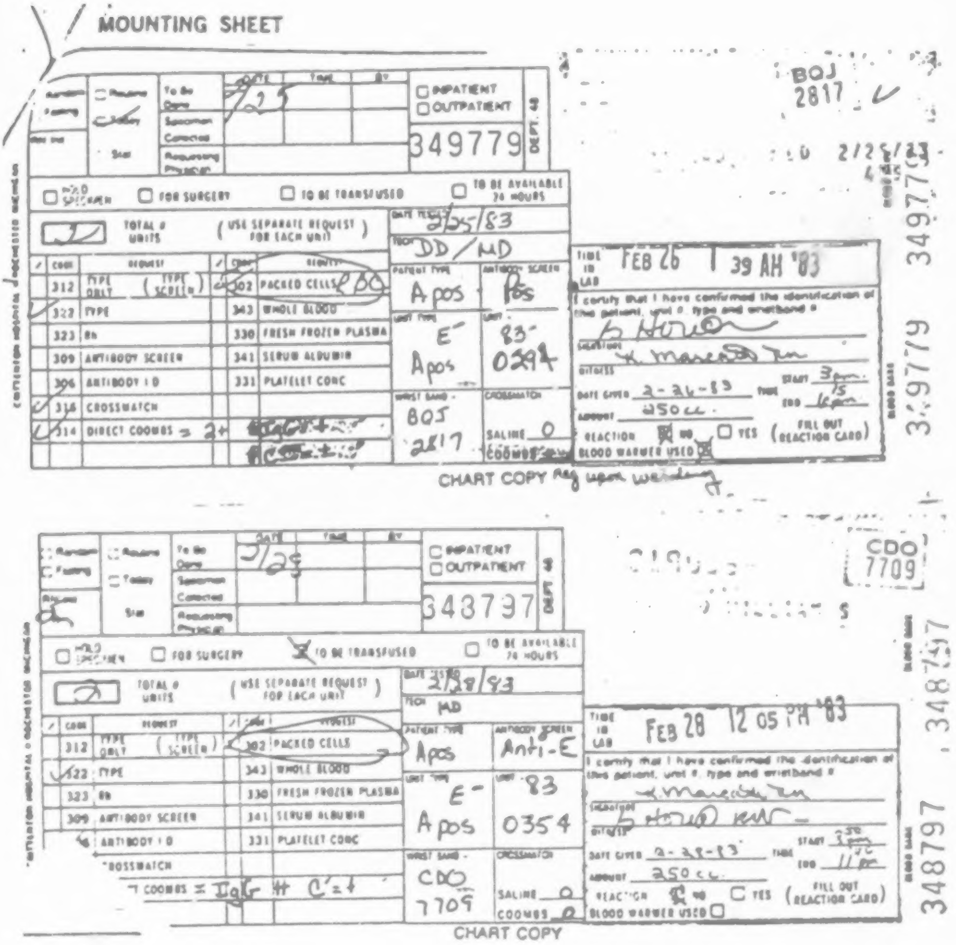
Working in the Department of Pathology (1944-45) was a veterinarian immunologist, R.R.A. Coombs, who became interested in the possible nature of the incomplete antibody. Following the death of Dr. Taylor in July 1945 and the appointment of Dr. Race as director, a Dr. A.E. Mourant joined the unit. (Coombs, Mourant, and Race, 1945)

Coombs, by a brilliant feat of intuition, had conceived the principle of the anti-globulin test. R.R.A. Coombs stated that he was traveling on an ill-lit wartime train from London to Cambridge, trying to read some papers by Ehrlich on the side-chain theory and Moreschi's 1908 antiglobulin theory, and speculating idly on the behaviour of red cells and antibodies. He visualized the cells, already coated with molecules of incomplete antibody, which was of course a globulin, but still floating free, becoming linked together by molecules of another antibody, an antiglobulin antibody.

Gamma-globulin was the protein fraction responsible for sensitization in the anti-globulin test. (Coombs and Mourant, 1947) The 'incomplete' antibody mainly responsible for positive anti-globulin test results is now known as IgG, while the 'complete' antibody is IgM.

As of 1985, Professor R.R.A. Coombs was still at the University of Cambridge. And Professor A.E. Mourant was in British retirement,fifteen miles off the coast of France.

The blood type example was from a patient who had had a hemolytic reaction and had to be transfused with blood containing special antibodies. The controversy between the discovery of the anti-globulin test and the patient's diagnosis was that a positive reaction to the Coombs' test becomes negative upon the blood-warming during transfusion, and all the antibodies disappear.



MOUNTING SHEET

Random / Fasting | ☐ Routine | ✓ Today | Stat
To Be Done: 2/25 | Specimen Collected | Requesting Physician
☐ INPATIENT ☐ OUTPATIENT
349779 DEPT. 8
☐ HOLD SPECIMEN ☐ FOR SURGERY ☐ TO BE TRANSFUSED ☐ TO BE AVAILABLE 24 HOURS
TOTAL # UNITS: 2 (USE SEPARATE REQUEST FOR EACH UNIT)

✓	CODE	REQUEST	✓	CODE	REQUEST
	312	TYPE ONLY (TYPE SCREEN)	✓	302	PACKED CELLS RBC
✓	322	TYPE		343	WHOLE BLOOD
	323	Rh		330	FRESH FROZEN PLASMA
	309	ANTIBODY SCREEN		341	SERUM ALBUMIN
	306	ANTIBODY I D		331	PLATELET CONC
✓	316	CROSSMATCH			
✓	314	DIRECT COOMBS = 2+			[illegible]
					[illegible]

DATE TESTED 2/25/83
TECH DD/MD
PATIENT TYPE A pos | ANTIBODY SCREEN Pos
UNIT TYPE E⁻ A pos | UNIT 83- 0294
WRIST BAND - BOJ 2817 | CROSSMATCH SALINE 0 COOMBS [illegible]

TIME IN LAB FEB 26 1 39 AM '83
I certify that I have confirmed the identification of this patient, unit #, type and wristband #
B Horton
SIGNATURE
K. Marecki RN
WITNESS
DATE GIVEN 2-26-83 TIME START 3pm END 6pm
AMOUNT 250cc.
REACTION ☒ NO ☐ YES (FILL OUT REACTION CARD)
BLOOD WARMER USED ☒

CHART COPY Neg upon warming

BOJ 2817 ✓
2/25/83
BLOOD BANK 349779
BLOOD BANK 349779

Random / Fasting | ☐ Routine | ☐ Today | Stat
To Be Done: 2/25 | Specimen Collected | Requesting Physician
☐ INPATIENT ☐ OUTPATIENT
343797 DEPT. 8
☐ HOLD SPECIMEN ☐ FOR SURGERY ☒ TO BE TRANSFUSED ☐ TO BE AVAILABLE 24 HOURS
TOTAL # UNITS: 2 (USE SEPARATE REQUEST FOR EACH UNIT)

✓	CODE	REQUEST	✓	CODE	REQUEST
	312	TYPE ONLY (TYPE SCREEN)	✓	302	PACKED CELLS
✓	322	TYPE		343	WHOLE BLOOD
	323	Rh		330	FRESH FROZEN PLASMA
	309	ANTIBODY SCREEN		341	SERUM ALBUMIN
	306	ANTIBODY I D		331	PLATELET CONC
		CROSSMATCH			
		COOMBS = IgG ++ C'=+			

DATE TESTED 2/28/83
TECH MD
PATIENT TYPE A pos | ANTIBODY SCREEN Anti-E
UNIT TYPE E⁻ A pos | UNIT 83 0354
WRIST BAND - CDO 7709 | CROSSMATCH SALINE 0 COOMBS 0

TIME IN LAB FEB 28 12 05 PM '83
I certify that I have confirmed the identification of this patient, unit #, type and wristband #
K. Marecki RN
SIGNATURE
B Horton RN
WITNESS
DATE GIVEN 2-28-83 TIME START 3:30pm END 11pm
AMOUNT 250cc.
REACTION ☒ NO ☐ YES (FILL OUT REACTION CARD)
BLOOD WARMER USED ☐

CHART COPY

CDO 7709
BLOOD BANK 348797
BLOOD BANK 348797

In a few short months, the patient's blood had an extremely high IgG level with enough infection in his body to disintegrate bones. The new diagnosis was: Fourth stage Hodgkin's disease/mixed celluarity.

As I studied the history of the blood type identification, my interest was aroused in 1983 to do a generic study on my family and me. THe respond was negative. So I asked again in '84. Finally I began a list of excuses from physicians, the blood bank lab, friends, and relatives.

1. Why? Why do I want an "insignificant" blood test?
2. This test means nothing!
3. Normal people don't want to know.
4. You have to be crazy to ask for an antibody test.
5. When a family member is the patient: The tending physicians threatened to walk off his case.
6. You have "no right" to antibody information.
7. Child observing all of the above: "Mother, if it's a choice of my having this test or you're being crazy, then 'you're crazy'."
8. It's cheaper to get a $50,000 a year blood disease, than do this antibody test.
9. You may find that the baby you left the hospital with isn't your baby.
10. The blood was drawned, and the test was not done, and there are "NO REFUNDS".

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: Lawrence Dilworith, Jr.

Address 13160 West Outer Dr. #108
Detroit, MI 48223

Representing : myself

****

I invite you to attach a prepared statement or to submit your written testimony:

I wanted to tell you how I've "fallen between the cracks." I had a job with benefits, but was laid off. I lost my benefits. After the lay off, I drew unemployment but couldn't afford medical insurance. I didn't qualify for assistance. I contacted DSS & I was able to get Medicaid. I had applied for disability since I am in a wheelchair. In 6 months it was granted, but since my income went up, I lost my medicaid. I tried to get Medicare, but you have to be disabled for two years before its granted. I'm now waiting for time to elapse + have absolutely no insurance. I must pay all my bills myself.

June 26

Senator Riegle,

I just now received your letter since I was out of town for 2 weeks. Altho I can't be at the hearing June 28th I want to tell you of my position.

I am a divorced mother. I was married 31 yrs and have been divorced for 2½ yrs now. My ex-husband was not required to pay alimony, medical, dental or house payments. I work for a Telemarketing Co that has laid off its employees 3 times in one year at no notice. I'm a hard worker & now find myself finding 2 jobs. I've raised 5 Children & am 54 yrs old.

-2-

I suppose I'll work until I drop over or become ill & lose everything. I have produced for the Company & been one of their top sales interviewers but they provide nothing at all Medical, vacation pay, Holidays etc. I am in a rut & afraid to try further for anything more. It seems as though all other age groups & circumstances are aided in one way or another except mine. They feel you have 2 legs, 2 feet and can make it on your own without any help. What do you think?

Sincerely,
Sigrid S. Dunning
4543 Harvard Rd
Det, Mi 48224

June 27, 1989
3422 Orchardale
Monroe, MI 48161

Senator Riegle:

I am a 41 year old female, totally disabled with ESRD, End Stage Renal Disease. I have just completed my third year on kidney dialysis. One of my major health problems is that I suffer from extreme anemia. This condition requires me to have one or two blood transfusions per week to keep my hemoglobin at a minimum level.

Erythropoietin is the drug I've waited and prayed for these many years. It was recently approved for use by the FDA in the United States. Thousands of patients have their hopes for a better quality of life dependent on receiving this hormone. Last week my doctor broke the terrible news to me that I couldn't begin treatment with erythropoietin because Medicare would not cover the cost of the injections. Finally, a drug that will help me with all the complications of getting so many transfusions and I can't receive this life-saving treatment because the cost is not covered.

I am paying for Medicare and Blue Cross, Blue Shield insurances myself. I can't afford to pay the $8,000.00 for these treatments on low income. Yet, is it justified to deny me these treatments when they can improve and quite possibly extend my life? Soon, with the rapid increase in antibodies, I won't be eligible for a kidney transplant. I am already showing complications from iron poisoning caused from the many transfusions.

Also, one last important issue. People in the mid-age bracket, over 30 and under 55 yrs. of age, who are disabled are falling through the cracks in the bureaucratic system. There are programs out there for seniors on Medicare; but when they find out we're under 55 yrs. of age they claim we don't qualify. I speak of this first hand as I've fallen into Many of these cracks.

I would like to take this moment to THANK YOU for taking the time and consideration in hearing our comments in this most important area of need.

Sincerely,

Frances Kay Dumont

Frances Kay Dumont

ENCLOSURES

June, 1989

June, 1989

FDA approves drug to combat anemia

WASHINGTON (NYT) — The Food and Drug Administration has approved a long-awaited genetically engineered drug to treat anemia in kidney patients, and experts said it also might help some people with AIDS and cancer.

The drug is a form of erythropoietin, a hormone normally produced in the kidney that stimulates the bone marrow to make the red blood cells that carry oxygen through the body.

The engineered hormone is the first of a new class of drugs that might allow doctors to control a patient's blood production.

Experts said the drug would be of immediate use to tens of thousands of kidney dialysis patients who must now endure blood transfusions to increase their red cell counts. They also expect it will be used to treat anemia caused by cancer and AIDS.

"I'm very excited about this," said Dr. John Adamson, the new president of the New York Blood Center, who did early research on the drug at the University of Washington in Seattle. "This drug will really make a difference."

Dr. Frank Young, the commissioner of food and drugs, said in an announcement yesterday that approval of the drug, epoetin alfa, is "a big advance," proof that the nation's investment in biotechnology is paying off.

The agency gave Amgen, Inc., a small biotechnology company in Thousand Oaks, Calif., exclusive approval to make and market the drug under the name Epogen.

Dr. Young noted that the drug was approved only for the severe anemia suffered by those with chronic kidney failure, estimated to be at least 95,000 Americans. But doctors are free to prescribe an approved drug in virtually any way they think might help a patient.

Besides kidney patients, researchers said, the drug holds promise for patients who may be anemic because of cancer or from radiation or chemotherapy that suppresses blood-cell production.

Gordon Binder, Amgen's chief executive officer, told a news briefing the drug would be available next week.

Ideally, he said, epoetin is given intraveneously three times a week in conjunction with dialysis. The company estimates the drug should cost each patient $4,000 to $8,000 a year.

Erythropoietin:

Promise and Fulfillment

By Joseph W. Eschbach, M.D.

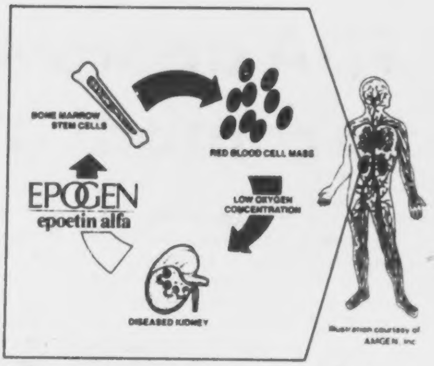


Illustration courtesy of AMGEN Inc

Taking its place in the cycle of red blood cell production, recombinant human erythropoietin (trade name EPOGEN, generic name epoetin alfa) is biologically indistinguishable from the body's own erythropoietin which the diseased kidney can no longer produce.

■ One of the most difficult challenges for persons with kidney failure is living with weakness, lack of energy and loss of well-being. The chief cause of this is anemia, an inadequate number of red blood cells. Virtually all patients with chronic renal failure are anemic, and until recently, the only treatment was blood transfusion. Now we have a substance that may solve this problem.

The substance is a genetically engineered hormone, recombinant human erythropoietin (r-HuEPO). In the vast majority of patients who took r-HuEPO in field trials, it eliminated their need for blood transfusions, made them stronger, and improved their quality of life.

Red blood cells provide oxygen to body tissues, and their production is controlled by erythropoietin (EPO), a hormone made in the kidney. Kidney disease damages the part of the kidney that makes EPO, and therefore anemia develops as kidney failure progresses. Dialysis has no effect on EPO production.

For the past 25 years kidney and blood specialists have thought that the "poisons" retained in dialysis patients caused anemia by suppressing the bone marrow. In 1984, after 15 years of research, my colleague Dr. John Adamson and I proved that EPO deficiency was the most likely cause. But EPO is present in blood in only minute quantities. How could a sufficient supply be obtained for patients who needed it?

After some 1,500,000 attempts, scientists at the biotechnical company AMGEN, Inc. succeeded in isolating the EPO gene and then reproduced it by inserting it into the nuclei of Chinese Hamster ovary cells, which are grown in tissue culture. The hormone, called recombinant human erythropoietin, or r-HuEPO, is literally mass-produced by these cells and secreted into the surrounding fluid, where it is removed and then purified. It was first tested in mice and dogs, where it proved effective and nontoxic. The first trials with human subjects began in December 1985. When Dr. Christopher Blagg and I first wrote about EPO in *Renalife* (May/June 1987), the initial results were very promising.

The Food and Drug Administration has just approved r-HuEPO for use by hemodialysis and CAPD patients.

A major hurdle still remains, however. The drug is already distributed in Europe, where it has cost about $8,000 a year per patient. We can only assume a similar high cost in the United States.

WHY IS r-HuEPO SIGNIFICANT?

When we first began treating patients with r-HuEPO, the goal was to bring hematocrits up to the mid-30s, and this was done in most cases. Within 8-12 weeks from the start of treatment the amount of red cells in the patients' blood doubled and they were no longer anemic. Transfusions were no longer needed by those who had previously required them. Patients who could not receive a transplant because of antibodies from transfusions eventually lost these antibodies. Iron overload from transfusions eventually improved as well, as the body used the iron to make more red cells.

Other responses were also impressive: patients were no longer short of breath with mild exertion, no longer taking daytime naps, sleeping better at night, no longer feeling so cold, less depressed and had better appetites. In certain cases angina (chest pains) disappeared, and sexual interest and function returned. In essence, their quality of life seemed significantly improved.

There is minimal, if any, direct toxicity from EPO. High blood pressure has developed or worsened in about one third of our patients, but this can be controlled with medication.

Research is now in progress to determine what other problems associated with kidney failure may be due to anemia instead of uremia, or whether these problems or complications are a combination of both factors. Heart enlargement, for example, is common and has been assumed to be due to a combination of high blood pressure and/or the toxic effects of uremia on the heart muscle. But chest x-rays show a significant reduction in heart size in many patients after their anemia is corrected. Brain function tests show significant improvement and exercise tolerance also improves. Whether these and other functions will return to normal remains to be determined, since many dialysis patients have been sick for a long time, and it is not yet clear whether or not these complications are completely reversible.

Twenty-nine years ago — March 9, 1960 — my mentor, Dr. Belding Scribner, started the first patient on chronic hemodialysis, made possible by his creation of the first permanent blood access. Since then, hundreds of thousands of patients with terminal kidney failure have been given this gift of new life. Now with the advent of recombinant human erythropoietin, these patients will also be given the gift of better health. ❏

Joseph W. Eschbach, M.D. is Clinical Professor of Medicine at the University of Washington, Seattle, Washington

A Patient's Story

By Hugh Hoffman

■ I was transfusion dependent for my first seven years on hemodialysis. A successful transplant raised my hematocrit to 40+%. Six years later, however, I had to return to dialysis and to the transfusions. But I soon stopped them after developing severe allergic reactions to blood products and fearing AIDS. With no transfusions, my crit stayed in the 11-13% range, and my activities were limited to being totally sedentary.

I received my first dose of EPO on January 28, 1987, and my crit began a slow, steady rise. After two weeks my appetite improved so much that I was warned about my high potassium levels. Once my crit reached 18% I stopped having tachycardia (rapid heartbeat) at meals and started to take short walks without strain, working my way up to 1.8 miles. After seven months my crit was 35% and my blood pressure had increased. Dialysis is easier and more comfortable.

I feel so improved — not only in physical stamina, but also in general motivation. After a long bachelorhood, I now want to round out my life with marriage. Each day I thank the Almighty that He sustains me in life and continually bestows numerous blessings upon me. ❏

Hugh Hoffman is a personal money manager. He lives in New York State and dialyzes at home.

EMPA-CARE IV, INC.

905 PENNIMAN
PLYMOUTH, MICHIGAN 48170
(313) 455-1061

June 13,1989

The Honorable Donald W. Riegle, Jr.
Michigan Regional Office
Wayne-Monroe
1850 McNamara Federal Bldg.
477 Michigan Avenue
Detroit, MI 48226

Dear Mr. Riegle,

I am happy to see you have a strong political interest on the problem of access to health care for uninsured individuals.

The problem of health care for the uninsured has been on of my primary concerns as I provide case management services through my home health care agency. This situation, the persons I personally, see most affected are young adults with physical disabilities (i.e. multiple sclerosis, muscular dystrophy and similar neuromuscular illnesses.) These persons (as well as thousands of other Michigan residents) need "financial" access to both long term care and hospitalization. Secondly, they are victims of public disenentives to full-time work. That is, if they work they may not have access to health coverage. If they don't work, they may receive Medicaid but have little left over for the cost of a personal care attendant.

Our company is placed in an interesting and frustrating position in the struggle for access to health care. Our home health aides do not receive health benefits through our employment at this time because of the associated expense. If we were to provide these benefits, our rates to the consumer would increase by perhaps 10 to 25 percent. In other words, if we provide access to health care for our employees, we may, at the same time, reduce access to home care to the average consumer - who could not afford our services.

Here I am the President of a home health care agency, an advocate for access to health care, that at the same time cannot provide access to health care for my own staff. That measures up to total frustration.

I believe that facts are facts. Someone (perhaps everyone) has to carry the financial burden to allow an entire nation access to health care. This would seem to demand a national health policy utilizing private resources where possible. A national health policy may actually create more jobs in the health care industry.

I hope to see you on June 28, 1989 at St. John's Armenian Church to hear our public's response to this critical issue.

Sincerely,

John R Fusik

John R. Fusik
President

JUNE 23, 1989,

HONORABLE DONALD W. RIEGLE, JR
1850 McNAMARA FEDERAL BLDG.
477 MICHIGAN AVE
DETROIT, MI 48226

DEAR SENATOR RIEGLE.

THANK YOU FOR THE INVITATION TO THE HEALTH HEARING SCHEDULED FOR JUNE 28. I AM SORRY, I WILL NOT BE ABLE TO ATTEND.

MY BIGGEST CONCERN WITH A PROGRAM OF THIS MAGNITUDE IS THE WASTE GENERATED EITHER BY THE LAXITY OF THOSE RESPONSIBLE FOR THE MANAGEMENT OF THE PROGRAM AT ANY LEVEL, OR OF PEOPLE ASSOCIATED WITH THE PROGRAM ILLEGITIMATELY OBTAINING FUNDS AS IN THE RECENT DISCLOSURE OF THE HUD PROGRAM.

MAYBE THE GOVERNMENT COULD PURCHASE HOSPITAL THAT ARE GOING OUT OF BUSINESS AND STAFF THEM WITH SALARY PAID DOCTORS AND NURSES

WE ARE GETTING VERY CLOSE TO SOCIALIZED MEDICINE WHICH I AM NOT SURE IS WORKING THAT WELL IN SOME PARTS OF THE WORLD.

MAY THE GOOD CORD LEAD YOU IN THE RIGHT DIRECTION

SINCERELY,
J. W. [illegible]
24165 TWIN VALLEY CT.
FARMINGTON, MI
48024

Epilepsy Center of Michigan
3800 WOODWARD — SEVENTH FLOOR
DETROIT, MICHIGAN 48201 — 313/832-0600

PEDIATRIC SEIZURE CLINIC
DIRECT LINE 313/832-1222

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OBTAINING PRESCRIPTIONS
A Basic in Epilepsy Treatment

The Epilepsy Center of Michigan, supported by United Ways throughout Michigan, during the past 40 years has served many thousands of individuals/families living with epilepsy. ECM knows well of a growing crisis for many uninsured individuals with epilepsy. They can not obtain daily medication they need to have their seizures controlled completely or partially.

Uninsured persons or insured persons without prescription coverage too frequently these days are unable to pay for medications prescribed by their doctors. ECM is not aware of any resource where a person can obtain without payment antiepileptic medication on a continuing basis.

Brief accounts of three individuals, of the many who this year have received emergency medication assistance from ECM, will illustrate why a growing number of people with epilepsy in Michigan and the U. S. today often lack access to needed medication. Consequently they continue to have epileptic seizures.

Jim is 21, and lives in central Michigan. He has had seizures since he was in the first grade. As long as he takes the 12 pills prescribed for him a day Jim is seizure-free and is able to work. His pay is low and his employer does not offer prescription coverage. The medications Jim needs cost him $161.31 a month.

Julie and her husband live in Michigan, but worked for a company in Indiana. They both lost their jobs when the company closed. Mike, one of their four young children, needs to take six pills each day to control his epileptic seizures. The monthly cost of the epilepsy medication for Mike in March was $59.18. Its cost most likely is higher today.

Bill, who was born in 1961, lives with his wife and child in Mt. Clemens. The 28-year-old man started to receive Social Security Disability Insurance in January

Supported by United Way of Michigan,
Detroit/Wayne County Community Mental Health Board,
Michigan Department of Mental Health,
patient fees, grants, contributions and bequests

1989. Since then he has been without Medicaid. His doctor wants Bill to take five antiepileptic pills a day. They cost him $51.49 a month, an amount he does not have. This June ECM paid for Bill's medication. He does not know how he'll obtain it in July. Unfortunately for Bill, neither does ECM know of any resource from which he might receive his needed medication.

Jim, Mike, Bill and thousands of other people having epilepsy have a serious problem with access to health care in the U.S. in 1989. If Michigan were to have a Medicaid Buy-In plan, Jim and Bill would not have to live in fear that they will be unable to obtain their prescribed medication.

Medicaid Buy-In legislation could minimize the access to health care crisis for many individuals and families trying to cope with epilepsy and its consequences in 1989.

June 28, 1989

Thomas J. Caughlin
Community Services Director
Epilepsy Center of Michigan

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Alice Foster R.N

Address 4534 Douglas
Flint, Mi

Representing : Community Health Nursing

****

I invite you to attach a prepared statement or to submit your written testimony:

I propose that their should be no deductible and complete prescription coverage for individuals qualifying under Title 18 & Title 19. They are at the poverty level Average income is $700 per month - if you take rent of approx $400 and 200 for gas, electric, phone and water Then take another $90-$100 out for medications that leaves them virtually nothing to live or eat on. This is not the way I or my co-workers like to see our mothers fathers and Grandparents living.

June 28, 1989

Mr Don Riegle, Jr.

I recieved the notice of the meeting througe the male on 6-27-89. It was to late for me to arrange to be at the meeting in Southfield so I'm Writing a letter.

I have been refused Health insurance on my job due to arthrites. I am not Cripple I have no defects I was told by my dr. that I have a form of arthrites that is eating away my bones but this has been for 10 yrs and I am still healthy. I have proof in letter form of my Allegation. Could you please tell me Where to turn. I am a single parent with all the responsibilities of having to work and pay for a home, Car, etc. I already have two outstanding medical bills to pay and I can't Get insurance through my job.

Please answer

Jean Ellison

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: [illegible]

Address 14[illegible]
[illegible] 48223

Representing : self

****

I invite you to attach a prepared statement or to submit your written testimony:

[illegible] Detroit, [illegible] health [illegible] substance [illegible]

Genesee County Health Care Access Project

Statement of

Bobby Pestronk, R.D., M.P.H.
Health Officer
Genesee County
Flint, Michigan

Mr. Chairman and members of the Committee:

My name is Robert M. Pestronk. I am the Director of the Genesee County Health Department.

I am here today representing a county agency charged by state code with protection and promotion of the public's health. Specifically the local health department endeavors to prevent diesase, prolong life and promote public health through organized programs in personal and environmental health. Health problems of particularly vulnerable populations are a specific focus for the Department. Citizens without health insurance or without adequate coverage represent a vulnerable population.

The uninsured

Who is without health insurance in Genesee County? A 1987 survey in Genesee county estimates the number of citizens without any type of coverage to be approximately 68,000. Some citizens despite adequate resources choose to be without coverage, but most who are uninsured have no choice. According to the recent study, 15% of Genesee County residents have no health insurance. This is higher than the state average of 11%. When broken out by income, the statistics are even more alarming. While only 12% of those earning more than 150% of the poverty level are uninsured, 41,665 individuals, or 27% of those earning less than 150% of poverty are uninsured. 11,029 of the low-income uninsured are children.

These individuals are without coverage for a number of reasons. Public programs such as Medicaid have eligibility requirements which restrict participation. Medicaid covers only 46% of those earning less than 150% of poverty. Funding levels for public programs have not kept pace with the demand. Additionally, many employers do not offer health coverage, or if they do, they may exclude dependent coverage or the cost to the employee may be more than the employee can afford.

A recent national study shows that more than 80% of the uninsured are affiliated with the workforce. This belies the traditional wisdom that most of the uninsured are unemployed. Employers choose not to offer health insurance for many reasons. Even some businesses which formerly offered insurance are rethinking their benefits. The escalating cost of health care has caused businesses to cut back on health insurance benefits in several ways: by partially cutting benefits, dropping coverage for dependents, dropping health coverage completely, or by shifting the cost of the premiums and coinsurance to the employee.

Additionally, small businesses have a harder time getting health insurance than larger businesses. And, when they are able to obtain insurance it costs them more than it does a larger business and of course the extra cost is usually harder to absorb for a small, marginal business. According to a recent publication by the American Hospital Association, businesses not offering health insurance usually have one or more of the following characteristics. The employees have low salaries; the business is small; it is unincorporated; and the business is in an industry where health coverage is uncommon.

The population of medically indigent and underinsured citizens is rapidly increasing. Economic and social conditions in Genesee County will continue to change over the next few years. Genesee County will experience the economic dislocation of many citizens employed in automotive and automotive related businesses. A proportion of these people will move from employment which provides health care to employment which does not provide health coverage.

There are programs in place for the uninsured, underinsured and unemployed. These involve public, private and voluntary organizations including such programs as Medicaid, general assistance medical, resident county hospitalization, public health programs such as WIC and family planning, and a range of voluntary and foundation supported programs. Local hospitals and physicians also contribute time and financial resources in the form of uncompensated care.

However, this system of programs is not comprehensive and it does not take the place of health insurance. These programs are specific to certain people with certain needs at specific times of their lives. Many believe that if a person without health insurance becomes sick they can simply go to the hospital or apply for Medicaid. This in fact is not the case at all. Without health insurance people do not take their children to the doctor, serious illnesses go untreated, and low income people are often stuck with unaffordable medical debts.

The Health Care Access Project

In Genesee County the Health Care Access Project (HCAP) is a demonstration project designed to increase access to health care for low-income working people and for persons receiving public assistance but not eligible for Medicaid. The program was implemented on January 1, 1988 and is currently providing health coverage for more than 9,000 individuals in Genesee County who receive General Assistance (GA). Prior to HCAP, these individuals had to get a referral from their case worker before going to the doctor. They had to apply separately for inpatient care benefits. Now, GA recipients receive a monthly identification card, like Medicaid. With this card they can go directly to a physician. And, when a person closes their case due to employment, they now receive a four month extension of their medical benefits.

These changes have significantly increased access to care for the 9,000 individuals receiving benefits. Prior to HCAP, these people saw a physician approximately twice a year, which is significantly below the national average of 4.5. Now, their utilization has increased to match the national average and that of the Medicaid population.

The more highly publicized portion of HCAP is the subsidy to small businesses. Currently, 74 businesses with more than 400 employees are receiving health insurance through the Health Care Access Project in Genesee County. In order to qualify for the subsidy businesses must operate in Genesee County, cannot have offered a group health benefit in the past two years, and must have hired a former welfare recipient since September 1, 1987. Once the business meets these criteria, all of their low-income (less than 200% of poverty) employees are eligible to receive a one-third subsidy of their health insurance premium. The business contributes one-third for all employees, and the employee pays according to their income. Employees who earn more than 200% poverty do not receive a subsidy. They pay two-thirds of their health insurance premium. Employees earning between 100 and 200% of poverty pay one-third, and for employees earning less than the poverty level, the project picks up two-thirds of the subsidy (and the business pays one-third.) Businesses can choose from a range of health insurance options including Blue Cross Blue Shield, commercial carriers, and one of the HMOs in Flint.

Of the 74 businesses enrolled in HCAP, most are in the service industry. The average size of the enrolled groups is five employees and the average age of these businesses is ten years. The businesses that have been eligible but have declined to participate with HCAP have been similar in size and type, but tend to be younger in age. Staff's sense is that the one major difference between the businesses that enroll with HCAP and those that don't is that the businesses that enroll have decided that health insurance is important to them. The businesses that decide against coverage site cost as the factor and yet it is unlikely that those business' financial position is actually any different from the businesses that choose to offer health insurance. Another interesting note about these businesses is that 23.4% of those approached and eligible for the subsidy have enrolled. This, in marketing terms, is an extremely high number.

Real People, Real Needs

There is a story for each of the 400 people receiving health coverage through HCAP, as well as the hundreds who work at businesses that decided not to enroll. There is no question that HCAP is affecting people's lives in significant ways. One of our first groups to enroll did so because of one employee - a former welfare recipient, a single mom, who couldn't get health coverage for her and her son because the son has hemophilia. She was seriously thinking of leaving her job to go back on welfare in order to get health insurance for her son. Because of HCAP she was able to keep working. The owner and wife of another company couldn't afford health insurance and were delaying starting their family until they could get health coverage. Now we understand a child is expected.

Implications for National Policy

Many lessons can be learned from HCAP. First, it's clear that the problem of health care for the uninsured is not a local problem and the solution cannot be handled on a local or statewide basis. Second, a voluntary subsidy program like HCAP cannot be a comprehensive solution by itself. There will always be businesses that choose not to participate and working people who remain uninsured. And third, the problem of underwriting and adverse selection must be addressed. The insurance industry is increasingly failing to insure the population. Instead, it excludes sick people and insures only the healthy. One business came to HCAP because its insurer told the owner that they would continue to raise his insurance premiums by 50% every six months until the business was forced to drop the coverage. It was a small business with an employee who had a serious illness. This leaves the burden of insuring the sick on the public sector and ultimately, the taxpayers. The only way for insurance to function as insurance is to pool the risk. The only governmental body that has the resources to address these problems is the federal government.

A model system

HCAP does provide a model for a system that is financed jointly by citizens, government, and business. Working people should have contributions planned over a lifetime with contributions figured progressively based on income. Policies should be set nationally to assure that services are uniform throughout the country. A comprehensive package of services should be available to all citizens.

GENESEE COUNTY MEDICAL SOCIETY

TESTIMONY ON HEALTH CARE FOR THE UNINSURED

PRESENTED TO THE UNITED STATES SENATE FINANCE SUB-COMMITTEE ON HEALTH JUNE 28, 1989

—W. Archibald Piper, M. D., President

The Genesee County Medical Society would like to thank Senator Donald Riegle and the Senate Finance Sub-Committee on Health for providing this opportunity to present our views on health care for the uninsured. The mercurial General Motors employment patterns in the Greater Flint Area make this a particularly timely hearing on an issue which is causing grave concerns for both the public and health care providers. There are currently three components to financing health care for the uninsured and under-insured. They are the subsidization efforts of: 1) Physicians on a patient by patient basis; 2) Hospitals on a patient by patient basis; 3) The government based insurance programs. Physicians in Genesee County have historically cared for the indigent with no reimbursement or with reimbursement that does not cover their cost of providing care. The Genesee County physician history of carrying forward indigent care activity goes back nearly 150 years. The purpose of this testimony is to explain why we feel, as advocates for the patients served, that Federal support for care of indigent people must be expanded to assure access, not hinderances to provision of services.

The time has come for the United States Congress to determine whether or not access to quality health care is a right or a privilege. Most voters, including physicians, feel that access to quality health care is a right. If health care is a right, it is the obligation of the public to financially support its provision. Currently, indigent care and care provided to the uninsured, is supported in large part by independent physicians and community based hospitals. Indigent care, which falls under the Medicaid program often reimburses physicians at less than 50 per cent of their costs for providing that care and hospitals at a rate below 100 per cent of the costs of providing such care. Consequently, the private factor is forced to accept the lion's share of the responsibility for the uninsured.

As mentioned earlier, physicians have willingly carried forth this duty for years. Is it fair for them to be forced to continue to do so? There are no liability waivers allowed for the care of patients who are indigent or supported by government sponsored programs. In spite of what some might think, physicians by and large are altruistic and consider it an obligation to assist humanity. Many physicians make time for medical missions where they give freely of their time and dollars to those who are truly in need and where they perceive this giving to be truly appreciated. This feeling and desire is not automatically perceived when dealing with the underprivileged here at home, for doctors carry the same liability to those patients as to others who pay fully. Patients on assistance sue as much or more than those who are not. Today, I spoke with a surgeon who has practiced for eighteen years. His two lawsuits have come from patients who paid nothing for their service. There was a time when liability premiums were low and it was possible to subsidize the uninsured by being fully paid by other patients, and it was easy to perform Pro Bono medicine. The health care environment today does not permit cost shifting between insurance coverages. Times have changed. Now few physicians find it possible to do such to a degree that they otherwise would. How long can one expect a neuro surgeon to go out at midnight for a trauma case if he is likely to get little or no reimbursement, is very likely to be sued, when this is the root cause of his malpractice premiums being $60,000.00 to $100,000.00 dollars?

Recently, in Flint, a member of the Genesee County Medical Society tried to set up a free clinic for the uninsured. He was able to put together over 100 volunteers including physicians, therapists, pharmacists, etc., but the clinic never got started because of the liability issue. He is still trying to find a way to ensure that these volunteers do not suffer financial ruin for the service which they are willing to provide without charge. It seems to us that government MUST BE IN THE EQUATION AND MUST PROVIDE SOME ASSISTANCE ON IMMUNITY WITH THIS LIABILITY QUESTION. To those who would gain from such service who argue that financial punishment is the only way to make doctors practice good medicine, I say Hogwash! Any person willing to give freely of his/her time is likely to do the best possible job they can and maloccurrences must be accepted as such, separate and distinct from malpractice. Most physicians are still independent practitioners who are self employed. As their indigent patient load increases, along with the liability risks associated with taking care of them, physicians are in increasing numbers being forced to limit or give up care of that population.

On June 8, 1987, Healthcare Review ran a front page article on the radical decrease in obstetricians and gynecologists willing to deliver babies in the Detroit area. According to this article, many of these physicians dropped their practices in obstetrics and concentrate totally on gynecology. The reasons for this are twofold. First, the cost of indigent care, and second, the cost of malpractice insurance liability risks. On the West side of the state, one community has lost 24 obstetricians-gynecologists, specifically due to the above two mentioned factors. A crisis is developing in access to care but not just for the poor. To illustrate the reasons for this developing crisis in access to care, allow me to quote some figures. One respected member of the Genesee County Medical Society is an obstetrician-gynecologist. In 1988, he delivered 135 babies. For each baby he received $688.00 in reimbursement. His malpractice premium was $50,294.00. This translates to $372.00 in malpractice insurance costs per baby delivered. The cost of malpractice insurance represents in his case 54 per cent of his reimbursement per baby delivered. After seeing numbers like that it is not hard to understand why physicians are beginning to become extremely upset at the level they must subsidize indigent care. This physician could save $10,060.00 by no longer delivering babies.

The Genesee County Medical Society recognizes that funds are not unlimited and that even the federal government cannot fund everything. We are also acutely aware that while physicians fees have been frozen and in many cases reduced; while insurers now unilaterally decide reimbursement patterns, and balanced billing is just about a thing of the past, that the cost of delivering services in every instance continues to rise. As a group, physicians cannot influence these economics. To even try would summon an FTC investigation. Those who regulate these controls must reflect on the long term consequences of making the medical profession less attractive. Already we see a pattern where the number of students applying to medical schools have fallen and those entering are no longer the cream of the crop. We strongly believe that the final recommendation of this Sub-Committee must include a provision for patient responsibility. Patients must come to know the cost of services and help decide where the limited amount of dollars available for their own care are to be spent. Any system providing services free of charge, either by physicians or government agencies without patient involvement in the decision as to how their quota of assistance money is spent, is doomed to failure. This principle is so basic and yet it is so poorly understood. Taking patient responsibility out of the system is one of the major causes for the continued spiraling health care costs. In no other economic model do you find a service received by one, delivered by a second, and paid by a third, or by no one.

As a final comment on indigent care issues, I believe that it is germane to know that studies performed in Genesee County have shown that access does currently exist for the general population regardless of their ability to pay. This committee must understand that there is a limit on how long this situation will exist.

The Genesee County Medical Society is an active and enthusiastic participant in The Robert Wood Johnson Foundation Funded Health Care Access Pilot Project (HCAP), overseen by the Michigan Department of Social Services and the Michigan League for Human Services. This is a program which will provide exciting data for future policy making. Our physicians participate in large numbers in this General Assistance oriented program because there is an awareness that the existing system does not work. The health care access project eases access to care while allowing the physician to provide that care which is needed. This care is provided at Medicaid reimbursement rates "below physician costs for providing the care," but without the traditional impediments towards providing care as the case management physician deems appropriate. We commend The Robert Wood Johnson Foundation, the State Department of Social Services, and the Michigan League for Human Services foresight in working with providers to help develop such an innovative project, dedicated to easing the access barriers which frustrate both patients and physicians.

The GCMS would like to recommend review of the Hatch Proposal for broad based national health insurance coverage. It, at first glance, appears to be an intriguing starting point for policy making.

This hearing is timely, and represents a promising start to intensive discussions of indigent care, which is of such great importance to today's environment. Once again, the Genesee County Medical Society would like to thank the Chairman, Senator Riegle, and the Senate Finance Sub-Committee on Health, for this opportunity to briefly present some of its views on health care delivery.

WAP/wjf

Charles C. Williams, Director
Genesee County Department of
Social Services

HEALTH CARE ACCESS PROJECT
Genesee County Michigan

GOOD MORNING AND THANK YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE THIS DISTINGUISHED PANEL.

MY REMARKS WILL BE DIRECTED TOWARD A HEALTH-CARE PILOT PROJECT CURRENTLY IN OPERATION IN GENESEE COUNTY. GENESEE AND MARQUETTE COUNTIES WERE SELECTED TO ADMINISTER THE EXPERIMENTAL PROGRAM WHICH BEGAN IN JANUARY, 1988 AND IS SCHEDULED TO CONCLUDE IN DECEMBER 1989.

THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES AND THE MICHIGAN LEAGUE FOR HUMAN SERVICES JOINTLY APPLIED AND WERE APPROVED FOR A GRANT FROM THE ROBERT WOOD JOHNSON FOUNDATION TO PROVIDE FOR THE PLANNING AND ADMINISTRATION OF THE PROJECT TO BE KNOWN AS THE HEALTH CARE ACCESS PROJECT (HCAP). THE PURPOSE OF THE PROGRAM WOULD BE TO DEVELOP A METHOD FOR PROVIDING NEEDED HEALTH CARE TO THE INDIGENT AND THE UNINSURED.

VERNON K. SMITH, DIRECTOR OF THE BUREAU OF PROGRAM POLICY FOR THE STATE MEDICAID DIVISION, WAS SELECTED TO DIRECT THE DEVELOPMENT OF THE H-CAP PROJECTS IN BOTH PILOT COUNTIES. DIRECTORS OF THE GENESEE COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS) AND THE GENESEE COUNTY HEALTH DEPARTMENT (GCHD) ACTED AS CO-DIRECTORS.

GENESEE COUNTY, WHICH INCLUDES THE CITY OF FLINT, HAS A POPULATION OF APPROXIMATELY 450,000. THE ECONOMY IS PRIMARILY INDUSTRIAL, ANCHORED BY GENERAL MOTORS' (GM) PRESENCE IN THE AUTOMOBILE INDUSTRY. THE AREA ECONOMY WAS SEVERELY DAMAGED BY THE DOWNSIZING OF THE GM WORK FORCE FROM AROUND 80,000 TO 47,000 EMPLOYEES FROM 1982 UNTIL THE PRESENT TIME. THE COUNTY'S WELFARE POPULATION IS SECOND IN THE STATE, SERVING SOME 70,000 FAMILIES, INDIVIDUALS AND CHILDREN. OF THE GENERAL POPULATION IT WAS ESTIMATED THAT 20 TO 25,000 INDIVIDUALS WOULD HAVE NO HEALTH CARE BENEFITS ON WHICH TO RELY WHEN NEEDED.

THE GOALS OF THE HEALTH CARE ACCESS PROJECT WERE CLEARLY DEFINED BY A LOCAL OVERSIGHT COMMITTEE CONSISTING OF STAFF FROM THE LOCAL AND STATE DSS, THE GENESEE COUNTY HEALTH DEPARTMENT AND THE MICHIGAN LEAGUE FOR HUMAN SERVICES. THE FOLLOWING GOALS WERE ADOPTED:

1. IMPROVE ACCESS FOR CURRENT GENERAL ASSISTANCE CLIENTS;
2. OFFER A HEALTH CARE PLAN TO FORMER GENERAL ASSISTANCE CLIENTS WHO HAVE MOVED OFF WELFARE AND BECOME EMPLOYED;
3. OFFER A HEALTH CARE PLAN TO FORMER CLIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN WHO HAVE BECOME EMPLOYED AND LOST THEIR MEDICAID.
4. OFFER A HEALTH CARE PLAN TO PERSONS WHO ARE POOR BUT NOT ELIGIBLE FOR MEDICAID BECAUSE THEY ARE NOT AGED, BLIND, DISABLED, OR IN FAMILIES WITH DEPENDENT CHILDREN;
5. DEVELOP THE ONE-THIRD SHARE PLAN WHICH WILL FINANCE THE COST OF HEALTH CARE FOR THE EMPLOYED INDIVIDUALS MENTIONED ABOVE, THEIR CO-WORKERS AND THEIR DEPENDENTS;
6. CONTRACT WITH HEALTH CARE PROVIDERS TO DELIVER MANAGED CARE TO THE TARGET POPULATION THROUGH EITHER A PREPAID OR MANAGED CARE FEE FOR SERVICE SYSTEM.

THE ONE-THIRD SHARE PLAN IS A UNIQUE PART OF THE PROGRAM DESIGN INVOLVING THE EMPLOYEE, THE EMPLOYER AND THE PROJECT, SHARING EQUALLY IN THE COST OF THE HEALTH CARE PREMIUM FOR FORMER WELFARE RECIPIENTS, THEIR CO-WORKERS, AND DEPENDENTS. EMPLOYEE CONTRIBUTIONS WOULD BE DETERMINED ON A SLIDING FEE SCALE IN ACCORDANCE WITH THEIR EARNINGS WHILE THE EMPLOYER'S CONTRIBUTION REMAINED CONSTANT AT ONE-THIRD.

THE ONE-THIRD SHARE PLAN WAS DESIGNATED AS A HEALTH DEPARTMENT RESPONSIBILITY. THE GCHD WOULD BE RESPONSIBLE FOR THE MARKETING OF THE PLAN TO LOCAL BUSINESSES AND WOULD HANDLE ALL OTHER ADMINISTRATIVE RESPONSIBILITIES.

EARLY IN THE DESIGN OF H-CAP, IT WAS RECOGNIZED THAT COMMUNITY SUPPORT WOULD BE CRITICAL TO THE IMPLEMENTATION OF THE PROGRAM. THIS ELEMENT WAS PART AND PARCEL OF THE EFFORT BY THE MICHIGAN

LEAGUE FOR HUMAN SERVICES IN BRINGING TOGETHER PUBLIC AND PRIVATE AGENCIES TO POOL THEIR IDEAS AND RESOURCES IN SUBMITTING A PROPOSAL.

GENESEE COUNTY PROVED ITS COMMITMENT TO THE CONCEPT OF H-CAP IN MANY WAYS. THE GENESEE COUNTY BOARD OF COMMISSIONERS DESIGNATED ITS $1.3-MILLION DOLLAR RESIDENT COUNTY HOSPITALIZATION FUND FOR THE H-CAP EFFORT. THE CHARLES STEWART MOTT FOUNDATION CONTRIBUTED $800,000 FOR MEDICAL PAYMENTS. THE FLINT AREA HEALTH FOUNDATION CONTRIBUTED THE COST OF A BUSINESS MARKETING AGENT. THE GENESEE COUNTY MEDICAL SOCIETY ENDORSED THE H-CAP CONCEPT AND IS PARTICIPATING IN THE PHYSICIAN SPONSOR PLAN. FLINT'S MAJOR HOSPITALS AGREED TO A 20% REDUCTION FROM MEDICAID LEVELS OF REIMBURSEMENT FOR H-CAP. THE BLUE CROSS NETWORK AGREED TO ENROLL PORTIONS OF THE TARGET GROUP INTO THEIR HEALTH MAINTENANCE ORGANIZATION (HMO). MONIES TOTALLING $7.5-MILLION FROM THE COUNTY, STATE AND MOTT FOUNDATION ARE POOLED IN THE SO CALLED, "LAST RESORT FUND."

SERVICES TO THE TARGET POPULATION ARE PROVIDED IN TWO WAYS, THE PHYSICIAN SPONSOR PLAN (PSP) AND THE BLUE CARE NETWORK HMO. PHYSICIANS ENROLLED IN THE PSP PROVIDE PRIMARY CARE AND AUTHORIZE OTHER CARE FOR THE ENROLLEE. ALSO, A CASE-MANAGEMENT FEE OF $3.00 PER MONTH PER ENROLLEE IS PAID TO THE ENROLLED PHYSICIAN. THE PHYSICIANS MONITOR PROVIDER PARTICIPATION BY MEANS OF A PEER REVIEW COMMITTEE OF THEIR OWN DESIGN.

THE BLUE CARE NETWORK IS PROVIDING CARE FOR GENERAL ASSISTANCE (GA) CLIENTS AND OTHER H-CAP GROUPS. THE GA AND OTHER ELIGIBLES ARE ENROLLED IN THE H-CAP PROGRAM VIA AN APPLICATION PROCEDURE AT THE LOCAL DSS OFFICE. THE ENROLLEE MUST CHOOSE EITHER THE PSP OR HMO PLAN AS HIS/HER HEALTH CARE PROVIDER. UPON ACCEPTANCE, THE ENROLLEE IS MAILED A MEDICAL CARE SIMILAR TO A BLUE CROSS OR OTHER MEDICAL CARE CARD, WHICH IS USED TO ACCESS THE HEALTH CARE PROVIDER.

WHILE THE PROJECT HAS NOT BEEN EVALUATED, SOME CLEAR TRENDS HAVE DEVELOPED. HOSPITALIZATIONS PAID UNDER THE COUNTY'S RESIDENT

COUNTY HOSPITALIZATION PROGRAM (RCH) IN 1987 WERE APPROXIMATELY 500. FOR 1988, UNDER H-CAP, APPROXIMATELY 2,500 HOSPITALIZATIONS HAVE OCCURRED WITH ANTICIPATED COSTS OF BETWEEN $7 & 8-MILLION COMPARED TO $1.6-MILLION IN 1987. TOTAL EXPENDITURES IN 1988 ARE ESTIMATED AT $13-MILLION AS OPPOSED TO $3.5-MILLION IN 1987. THE NUMBER OF HOSPITALIZATION UNDERWRITTEN UNDER THE COUNTY RCH PROGRAM IN 1987 WAS 500. THIS NUMBER WILL INCREASE TO APPROXIMATELY 2,500 IN 1988 UNDER THE H-CAP PROGRAM.

THESE NUMBERS CLEARLY REPRESENT A MARKED IMPROVEMENT IN ACCESS TO HEALTH CARE IN GENESEE COUNTY. WHILE THESE RESULTS INDICATE SUCCESS IN REACHING THE PRIMARY GOAL OF INCREASING HEALTH CARE ACCESS, SEVERAL POLICY CHANGES ARE BEING CONSIDERED IN ORDER TO CAP TOTAL EXPENSES OF THE PROJECT AT AROUND $9-MILLION, MORE IN CONCERT WITH THE PROJECT BUDGET. A ONE-YEAR EXTENSION OF H-CAP IS BEING PURSUED IN ORDER TO GET A BETTER PERCEPTION OF ALL ASPECTS OF THE PROGRAM. AN EXTENSIVE EVALUATION WILL TAKE PLACE AT THE CONCLUSION OF THE PILOT STUDY.

THE ONE-THIRD SHARE PLAN PRESENTS A UNIQUE OPPORTUNITY FOR EMPLOYERS TO PARTICIPATE IN HEALTH INSURANCE FOR THEIR EMPLOYEES. THE H-CAP STAFF OF THE GENESEE COUNTY HEALTH DEPARTMENT DID A REMARKABLE JOB OF PACKAGING AND MARKETING THE PROJECT. DESPITE THE NEWNESS OF THE CONCEPT, THE PLAN IS RECEIVING ENCOURAGING RECEPTION FROM THE BUSINESS COMMUNITY. AS OF LATE MAY, 1989, SEVENTY-FOUR BUSINESSES HAD ENROLLED IN THE ONE-THIRD SHARE PLAN FOR EMPLOYEE HEALTH CARE COVERAGE. THIS INDICATES THAT THE PLAN IS COMPETITIVE WITH RESPECT TO COSTS AND COVERAGE WITH OTHER AVAILABLE HEALTH BENEFIT PLANS. IT IS EXPECTED THAT THIS PROJECT WILL SHOW MORE FAVORABLE RESULTS WITH ONE ADDITIONAL YEAR TO RUN AND ENGAGE IN A COMPREHENSIVE EVALUATION.

THE JURY IS STILL OUT IN TERMS OF WHETHER OR NOT H-CAP IS THE MODEL TO ADOPT IN EXTENDING HEALTH CARE ACCESS . IT IS, HOWEVER, ONE APPROACH TO ALLEVIATING A VERY SERIOUS PROBLEM IN OUR HEALTH CARE SYSTEM.

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Pete [illegible]

Address 1038 [illegible]

[illegible], Mi. 48[illegible]

Representing : Myself

****

I invite you to attach a prepared statement or to submit your written testimony:

[illegible] an attempt

to [illegible]

for [illegible] health insurance

[illegible]

[illegible]

December 15, 1988

Ref: SSD - Social Security Disability
SSI - Suppkemental Security Income
MDSS - Michigan Dept. Social Services

Dear Sir:

I am a woman of 53 forced to go on Social Security total disability due to a heart condition. In the interim of waiting for SSD, I applied for SSI & welfare. After going through my savings of $8900.00, I received two months of welfare checks totaling $613.00. That money had to be paid back when I started getting the SSI checks. I received an SSI check in the amount of $767.83, of which $613.00 was promptly paid back to MDSS. While receiving welfare checks I was eligible for Medicaid. My SSD checks started arriving in Oct. 1988. of $514.00 per month, now I am told that I make too much money for Medicaid. MDSS gives me an allowable income of $385.00 and I must incur $654.00 in medical expenses for a period of 6 months(with a review every 6 months). This also applies to hospitalization if the need occurs. At this point I am receiving $38.00 a month in food stamps. I am not eligible for Medicare for two years and I had to give up my Blue Cross/Blue Shield due to failure of payment -- no money. I have had two replacements of the mitral valve open heart surgeries and I was hospitalized in March, 1988 with a severe bout of congestive heart failure. I have been left with an ejection fraction of 12% of the left ventricle, and need a lot of medication and visits to the doctor. Please tell what steps to take to get better medical assistance. It is impossible to maintain my house and medical expenses on $514.00 a month. The government continues to send money to foreign countries, while the little people here go without and continue to lose what they have worked for all their life. There has to be an answer to help us. In order to have received any kind of help, I had to go through my entire savings, now they expect me to have money to meet the needs that are keeping me alive.

According my social worker, when SS goes up in January, my allowable income will also increase. I HATE TO THINK THAT THE ONLY WAY OUT IS SUICIDE. IF I DON'T DO IT, BUREAUCRACY WILL DO IT FOR ME.

Please acknowledge letter, thank you???

I remain,

Darlene Goddu
Darlene Goddu

ALL TOTALS BELOW ARE MULTIPLIED BY SIX MONTHS

#1 ACCORDING TO MDSS

Income	$514.00		
	-20.00	Standard deduction	
	$494.00		$2964.00
	-385.00	Allowable income	2310.00
	$109.00	Medical expenses to incur	654.00

#2 MEDICAL EXPENSES

Prescriptions	$193.10		1158.60
Heart Doctor	35.00	monthly visits	210.00
Psyciatrist	65.00	2 - 3 mon. visits (Manic Depressive)	129.96
EKG	50.00	3 mon. interval	99.96
Blood Test	20.75	monthly	124.50
			$1,723.02
Blue Cross/Blue Shield if affordable $126.63(co-payment plan)			759.78
			$2,482.80

Blue Cross/Blue Shield will not pick up a pre-existing condition for 180 days.

#3 HOUSEHOLD EXPENSES

House payment	$269.00		$1,614.00
Consumers	69.00	Budget plan	414.00
Edison	32.00	Approx. Winter Bill	192.00
Phone	22.00		132.00
Water	20.00		120.00
Car Ins.	56.00	Compulsary for transportion	336.00
			$2,808.00
		Plus #2 MEDICAL EXPENSES	1,723.02
			$4,531.02
	By the Grace of God	Blue Cross/Blue Shield	759.78
			$5,290.80.

Tell me how.

Darlene Goddu

Darlene Goddu
19422 Coleman
Mt. Clemens, MI 48043

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

C. PATRICK BABCOCK, Director

Darlene Godde
19422 Coleman
Mt. Clemens, Mich 48043

Case Name Darlene Godde			
Case Number V24752434			
County 50	District 12	Unit 1	Worker 4
Date 12-13-88		Other ID (As required)	

If you do not understand this form, call the Department of Social Services.
Si Ud. no entiende esta noticia, llame por telefono al Departmento de Servicios Social.
إذا كانت صعوبة في فهم هذا الطلب - الرجا الاتصال بدائرة الخدمات الاجتماعية

Your application for medical assistance (MA) has been denied because, based on medical assistance standards, your projected income for the six month period 12-1-88 through 5-31-89 will exceed your needs by $ 654. The legal base for this denial is 42 CFR 435.831(d).

However, if you notify this office that you have incurred allowable medical expenses equal to $ 654 before 5-31-89, you may be eligible for MA for part of the six month period shown above. Please contact me for an explanation of allowable medical expenses. On the reverse side of this letter is a form on which to list your medical expenses as they are incurred. Proof of incurred expenses is required. Examples of proof are bills, receipts and written statements from your medical care providers.

If your allowable medical expenses equal $ 654 before 5-31-89, notify this office immediately. The amount shown above may increase or decrease if there are changes in your circumstances, such as changes in your income or family size. Therefore, notify this office immediately of any changes in your circumstances.

If your allowable medical expenses do not equal $ 654 before 5-31-89 or you do not notify this office of your expenses by that date, you will not be eligible for MA for any part of the six month period shown above.

If you believe this denial is illegal, you have the right to a hearing. A request for a hearing must be in writing, signed by you or your authorized representative, and received by the Department within 90 days following the date of this letter. Hearing requests should be sent to your local Department of Social Services. You are entitled to representation by an attorney or other person of your choice. However, this Department does not reimburse for any legal expenses. If you have a handicap which may affect your ability to participate in a hearing, you have a right to a hearing room which is accessible. The Department will pay for a language interpreter or provide other help, if needed. Please contact your local Department so that appropriate arrangements may be made.

AP Worker ______________

Telephone Number 469-7213

______ County Department of Social Services

AUTHORITY: 42 CFR 435.
COMPLETION: Voluntary.
PENALTY: None.

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

DSS-114 (Rev. 8-87) Previous edition obsolete.

TESTIMONY

25083 Pattow
Roseville, Michigan 48066
June 28, 1989

Dear Senator Riegle, Jr.

SUBJECT: EXORBITANT HEALTH CARE COSTS FOR THE INDIVIDUAL NOT YET 65

For how long can a widow or individual be expected to pay the high rates charged by the wealthy health insurance companies? I am speaking for the people who have not yet attained the age of 65 and not yet on Medicare.

In August, 1988, when I applied for Golden Rule Health Insurance, I paid premiums of $390 every three months with a $250 deductible. Within three months, I was advised that the same insurance would rise to $500 every three months with a $500 deductible!!!!

If this company raises its premiums one more time, I shall be forced to cancel out, and just hope and pray that my good health continues - at least until I reach Medicare age.

We ask your help, Senator Riegle. We can't be without some kind of health insurance should sickness strike. Yet, we can't afford the exhorbitant premiums either.

Thank you.

Helen Grandall
(Mrs.) Helen Grandall

June 30, 1989

Dear Senator Riegle,

We were out of town when your very interesting letter arrived As far as my entire family all adults except for One Grandchild. Only my husband and myself are covered ~~for~~ by Blue Cross & Blue Shield and of Course if one of us or both became very seriously ill such as Cancer - ALS etc We would not be covered for long three adult Children live at home 2 pay for insurance that only very minimal coverage our oldest Son out of Work at this time has nothing Our oldest daughter Unmarried has been dropped from Medicaid because her Boyfried is Working her Boyfriend and Baby are covered only minimal Coverage. We were just In Canada And their health Care is Quite Wonderful What ~~Our~~ citizens Can We do to affect Change in the Wonderful Country of ours

Thank You

Jacqueline Green

July 12, 1989

United States Senator
Honorable Donald W. Riegle, Jr.
700 Washington Square
109 W. Michigan Avenue
Lansing, Michigan 48933

Dear Senator Riegle:

In regard to the hearing on healthcare I am sorry I couldn't make it but would like to express my views.

It is appalling to me that we have a high infant mortality rate in the State of Michigan. This is partially due to unavailable health care and follow-up of the pregnant woman who is poor, unemployed, divorced and/or uninsured.

Another issue that breaks my heart is the older American. Most of these people have paid into the system all of their lives and are not afforded good health care and housing in their twilight years.

One last sore spot is the workers that were laid off by General Motors and other automobile manufacturers who lose their health insurance and have to lose everything they own before they can receive Medicaid.

As the great society that we are we should "take care of our own". I feel some ways this can be achieved is to:

1. increase taxes to insure all elderly people, poor people and those who are working at entry level jobs and cannot afford health insurance with quality health care.
2. provide malpractice insurance to those hospitals, clinics and health care personnel that provide services to this population of people.
3. have insurance companies pay the same amount of money for services rendered whether the procedure is performed in an office, clinic or hospital.
4. have all employers provide health insurance to all their employees including part-time help. The small companies who cannot afford it should at least pay a portion of it and the state, city or county pay the rest.
5. Maintain health care (Medicaid) to those individuals that improve their position and get off of welfare but still cannot afford health insurance and their employer does not provide it.

No one living in America should be denied quality medical care. The answers are there. Many people are getting rich from our inadequate system and others are dying, neglected and denied medical care. The brains that orchestrate the buyouts of many health care institutions, make tremendous profits and deny uninsured patients health care should be used to solve the problem from the other end with the uninsured, poor and elderly.

Thank you for allowing me to express my views. Good luck with this difficult problem. You have my wholehearted support in your endeavors with this issue.

Sincerely,

Agnes B. Hagan

Agnes B. Hagan
5364 Dearing Drive
Flint, Michigan 48506

AH/dmc

HANDICAPPER
SMALL BUSINESS ASSOCIATION

1900 South Cedar Street, Suite 112, Lansing, Michigan 48910
517-484-8440 (Voice/TDD)

June 24, 1989

The Honorable Donald Riegle
United States Senator
Michigan Regional Office
705 Washington Square Building
109 West Michigan Avenue
Lansing, Michigan 48933

Dear Senator Riegle:

As the Executive Director of the Handicapper Small Business Association, I encounter the negative affects this nation's access to health care problems have on handicappers seeking independence through self-employment on a regular basis. Often times, the only reason these talented individuals are unable to leave the Social Security or Long-term Disability rolls is their inability to access reasonable health insurance coverage. And, most of the time health insurance coverage is not available at all to this group of individuals at any cost.

The issue of access to health care must be resolved. It is costing this nations in more ways that I beleive most are willing to admit. In a recent study completed by the Michigan Board of Education, surveys indicated that 85% of Michigan's non-institutionalized population (aged 16-64) were unemployed. Additionally, the surveys revealed that 52% of those individuals were interested in self-employment, small business ownership, or employment from a home-based worksite. Considering that all other obstacles could be dealt with and opportunites can be made available for individuals in small business enterprise, the lack of access to health care or health insurance at reasonable costs restrict most individuals from pursuing self-employment.

The result of this critical problem is the loss of potential jobs for a highly unemployed group of talented underutilized individuals. Handicappers hire handicappers. Through the development of strong handicapper owned businesses throughout Michigan and the country, the unemployment rate of handicappers will be proportionally decreased. Obviously access to health care is not the only special issue handicappers face when starting businesses. However, it is probably the most uncontrollable at this time.

Solutions to solve the problem may include allowing handicappers to continue to collect medicare/medicaid once their businesses have started if reasonable health insurance is not available. The cost savings to social/welfare programs in monthly compensation allowance would far outway the "difficulty" in managing this type of program.

Implementation would provide a needed incentive for most individuals to take the risk of becoming independent of social/welfare programs. When heath care is a concern, all the positive reasons for leaving a program become secondary and often times totally irrelavant. Also, it would be helpful to provide opportunities for handicappers not currently recieving medicare/medicaid to buy into the program at a reasonable cost (possibly sliding scale) if they do not have another alternative for health insurance.

The leaders of this nation have recognized and provided programs to aid in the relief of special economic development issues as they pertain to both women and ethnic minorities. It is time attention is paid to the millions of capable handicappers in this nation who are trained, ready and able to make their contribution through small business ownership. Access to health care, entrepreneurial education and capital are the three primary issues this group faces. If you have any questions, please do not hesitate contacting me.

Thank you for your time, attention and support.

Sincerely,

Kimberly A. Carter
Executive Director

June 16, 1989

Senator Don Riegle
705 West Washington Square Bldg.
109 West Michigan Ave.
Lansing, Mi 48933

Dear Senator Riegle:

I welcome the opportunity to address the issue of health care from my very personal point of view.

Unfortunately I am unable to join you in person at this important hearing, As care for my wife, who has chronic progressive multiple sclerosis takes priority, and time and distance make it impractical for me to testify in person.

We, Rebecca my wife, and I would appreciate your reading and entering into the record our written testimony as follows:

In February, 1984, one month after the demise of my mother who shared our home, my wife was diagnosed as having chronic progressive multiple sclerosis. The effect of these two extremes have critically strained our resources.

In 1987 my wife underwent a protocol for treatment of chronic progressive multiple sclerosis, physical therapy was prescribed as an integral part of this treatment. The attending neurologist specifically noted physical therapy was important to the patient during this treatment period and should not be interrupted.

However, with incredible indifference to his letters, Medicare denied therapy stating the patient had reached her "maximum potential and the services were not considered to be a specific and effective treatment for your condition under accepted standards of Medicare practices".

Since that time I have been, to the best of my ability, providing the physical therapy for my wife.

Medicare, in failing to respond to the physician's orders, violated my wife's rights under the Medicare Statute, the Administrative Procedure Act, and the United States Constitution.

Medicare prohibits a distinction between chronically ill and acutely ill patients requiring a skilled care. There is no evidence supportive of the conclusion that chronically ill individuals with multiple sclerosis have no restoration potential and therefore are not candidates for skilled physical therapy.

The Department of Health and Human Services ("H.H.S.") and its component, Health Care Financing Administration (H.C.F.A.) is abdicating its legal responsibility and thwarting the Medicare Statute by delegating primary decision-making authority to private fiscal intermediaries without adequate supervision or regulatory mandate. As a result, Medicare patients and providers of home health care services are faced with irrational and unexplained coverage determinations which fail to take into account and consideration individual patient needs, the attending physician's opinion and community medical practice.

The Medicare Program,administered by the Department of Health and Human Services through the Health Care Financing Administration,is a system of health insurance for the aged and disabled--Medicare Part A., covers the costs incurred by eligible beneficiaries for certain hospital and home health services. Part B. covers physicians and other supplemental services including home health care. Home health agencies provide Part A. services in patients' homes as a more economical alternative to institutional care.

In plain language, the cost to government for the care to the infirm is greater if the patient is forced into institutionalization, and less if patient can be maintained in their own home. The obvious choice aside from the physiological benefits patients derive is the latter; to that conclusion, I submit any assistance that can improve that alternative would be desirable and should be encouraged and further erosion of the health care benefit abetted by State elected officials contradicts congressional posture which has consistently been an advocacy of home care for the elderly and infirm of this nation.

Since my advocacy of Rebeccas's treatment ironically, after a year's interval, she is now receiving some therapy on an interim basis.

The complex restrictive and prohibitive regulations of the health care system have, as mentioned earlier in this testimony, compromised our homestead, ie?

(1.) Medicade benefits to my wife would be diminished if I earn more than seventy-five dollars (75.00) per month.

(2.) Social Security Disability benefits pays my wife Five Hundred Seventeen (517.00) per month. I receive no assistance as able spouse although I am in service twenty-four hours daily.

(3.) Medicare - Medicade expenses on my wife's behalf approximate Five Hundred Seventy (570.00) per month.

(4.) Total household income currently is Five Hundred Ninety-two (592.00).

Our home, 29.33 acres inclusive of one acre of producing blueberries with an income potential in excess of Eighty Thousand (80,000.00) per annum - sufficient enough to effect our independence of the health care system, could be lost.

(5.) Household expenses exceed Eleven Hundred (1,100.00) per month.

The "system" will place a (worker chore person) in our home to assist me in household maintenence on a three hour per day six days per week schedule. However, that service is of no benefit to me or my wife. As a result of these issues my wife and I are literally being forced by State and Federal Law into legal deprivation. Apparently no laws or agencies are available to us that can alter this course of events.

In my opinion all assistance should be given to persons who aspire to be free of the "Health Care System" if in fact they demonstrate the desire and ability to function independently without detriment to themselves. The limits placed on my wife and myself by "law" that prevent our pursuance of our constitutional rights are violations that should be addressed, they should not be allowed to prevail. By law they should be abolished.

Our position is critical. If nothing is done, we, my wife and I, will be forced from our home. Rebecca would have to be institutionalized, and I will be relegated to the numbers of the homeless.

- Is this the American Dream! -

Sincerely,

a Randall Harris

A. Randall Harris
76396 38th Avenue
Covert, Michigan 49043
(616) 764-8884

6-26-89
Wyandotte, Mi.

Dear Senator Riegle,

I wish you much success in your endeavors to try to get affordable health care for the uninsured. It is long past due and a great concern to me for all people who need and should have health care. I have insurance but I feel guilty that I have, and my daughter and her family dont. I neglected to go to the Doctor until the 6th of June. when I found my b.p to be 220/120 - my cholesterol 314 and heart problems which have caused blockage.

My daughter's husband is ill - paranoia schizophrenia. Because of his condition he is unable to work out, and incapable of keeping the boys so she could work and try to get insurance benefits. He's suicidal at times and is constantly controlled by "the voices". It's so sad - he is a wonderful person 33 yrs. old He is on medicade but she & the boys are not entitled for some reason.

Last month their youngest son was injured and his head required 8 stitches.

The hospital bill was $206.00 (E.R etc) and two follow up office visits was $55.00. It'll take her a while to pay off the hospital bill with the high cost of rent, food, utilities etc on their Social Security disability.

I believe medical care is a basic human right and I hope and pray it will soon be affordable to all.

Sincerely
Carolyn R. Harrison
1864-18th Street
Wyandotte, Mi

Sorry I can't attend the meeting but I have a Doctor Appt and can't be there.

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: Esther Hasbrouck

Address 321 Maple
Howell, MI. 48843

Representing : OLHSA

****

I invite you to attach a prepared statement or to submit your written testimony:

Senator Riegle,

I am representing Oakland Livingston Human Service Agency Livingston County Field Services. In working with the low-income I have contact daily with the medically uninsured. Our numbers of uninsured seem small compared to the urban area but even one person going without medical services is too many.

A small citizens group with our help implemented a program that pays for prescriptions, doctors and/or dentists visits. This program is funded strictly by local donations. Obviously it by no means pays for more serious illnesses or hospital costs. WE NEED HELP!

HEPFNER & ASSOCIATES INC.

Suite 142 - 3290 West Big Beaver Road, Troy, Michigan 48084
(313) 643-8916

June 19, 1989

Honorable Donald W. Riegle, Jr.
Wayne-Monroe Office
1850 McNamara Federal Bldg.
477 Michigan Avenue
Detroit, MI 48226

Dear Senator Riegle:

In follow-up to your letter of June 5, 1989, concerning the upcoming Senate Finance Subcommittee hearing on health care, I regret that prior commitments will not permit me to be in attendance. However, I would like to provide this written testimony, as you requested, because I have been on both sides of the issue.

First, I have been a licensed agent for over 20 years, and last year I was a buyer of health insurance. Over the years, just finding health insurance for individuals, and even small groups (generally under 25 lives), has been difficult. This has been an area that has been neglected by the insurance industry in my opinion. The argument always has been that Blue Cross-Blue Shield is so predominant in Southeast Michigan that there is not enough leftover market share to make this business profitable. After you find the policy, then you have to address the issue of cost and getting it issued. In my own case, I have recently bought a relatively large amount of life insurance issued on a standard basis with waiver of premium benefits and discounted for not smoking cigarettes. At the same time with the same medical data, I have a major medical policy that excludes coverage for: Any eye impairment and diverticulitis or diverticulosis. Since premiums and coverage are not guaranteed, I can only look forward to rising premiums and more exclusions if I should be cancelled or try to change carriers, and I am basically a healthy individual.

I don't know if health care is the most serious problem facing America, but it surely has to be in the top ten. The cost to solve this problem is high. It has been said that General Motors has more cost in an automobile for health insurance than it does for steel. Many small businesses cannot pass that much cost on to their customers, particularly in a service business.

Honorable Donald W. Riegle, Jr.
June 19, 1989
Page 2

Unfortunately there are probably no easy solutions. I do feel the problem should be addressed and solved with a coalition of leaders from both the Federal government and the insurance industry. I think the government should set the standards and assure the availability of coverage, while the insurance industry should deliver the product and pay the claims. The cost of the coverage has to be paid by the individual. It always is anyway, either directly or indirectly.

Thank you for your consideration to my comments, and good luck in your hearings. If I can provide any additional information, please feel free to contact me at the letterhead address. Naturally, I would be interested in keeping up to date as to the progress you are making and the direction your work is taking.

Sincerely,

Alex H. Hepfner

Alex H. Hepfner
President

cc: Washington, D.C. Office

AHH/ct

Mr. Reigle,

In regards to your letter of June 8, 1989 I am so glad someone is trying to help those who are medically uninsured or those paying the very high individual insurance rates.

I have been going to the Michigan Headache and Neurological Institute in Ann Arbor for several years. I have to pay $85.00 per visit plus my prescriptions. They felt that my job was detrimental to me, so in trying to help myself, I went to the Lansing Community College Truck Drivers School in Battle Creek. After passing their course, I was unable to find a job as they only want expirenced drivers. I am considered Vocationally Handicapped due to my headaches. After a few months without any success job hunting, the pressure became to much and I attempted suicide. I know I made a big mistake. I spent some time in the hospital — without insurance. The doctors wanted to run a stress test on me but because I was uninsured they couldn't.

I am still out of work and so I can't afford to get any health insurance.

I certainly hope there is some way you can help me and others in the same position as me.

I am going to try to make it to your meeting if at all possible.

Sincerely
Gregory A. Hinyman
28862 Sheridan
Garden City, Mi.
48135

Help the Elderly Maintain
Independence and Dignity
hemid

MRS. MURIEL NARRING, Director

1100 E. STATE FAIR
DETROIT, MICHIGAN, 48203
891-1038

June 28, 1989

To Senator Riegle and Members of Senate Sub-committee
on Health:

The accelerating costs of Medical Care have made it unavailable to many people. The ones we see who are hurting the most are low-moderate income young families and elderly people. Those whose incomes are low enough for medicaid fare somewhat better than the ones who are struggling to maintain themselves on low income jobs.

Preventive medicine is just about out for many of them. Many do not even have a doctor to contact, if they become ill. Insurance premiums are way out of sight for them so they remain uninsured and vulnerable.

Until we have some kind of good universal health care in our country many of us are at the mercy of doctors, hospitals and clinics that charge high fees for every kind of service. Health costs are inflated by a multiplicity of tests, some not really necessary but given to protect the doctor in case of legal action.

The new catastropic health care program has imposed another burden on those least able to afford it. Someone trying to live on about $400.00 a month cannot afford another $4.00 for care that most of them will probably never need. The in-home support services and even nursing home charges are what they need help with as they get older and frailer. Many people would not need to be in nursing homes if there was adequate provision for home health care support. They would be happy in their own home and it would be less expensive.

Long term care is a serious problem crying for a solution that will preserve people's dignity. We are grateful that congressmen are coming out to listen to the problems first hand. We pray for success.

Muriel Narring
director

MN/man

17134 Fenmore
Detroit Michigan
June 27, 1989

Senate Finance Subcommittee on Health;

I am a 49 year old female poor health, raising two grandchildren. One 8 years old and one 3 years old. Their mother died May 19, 1987. I applyed to Social Security to see if they had any benefits from their mother depth. It was aproved. I receive the first payment January 1968. At that time my income was cut off which was general Assistance. I reapplyed for Assistance August, 1988. At that time I was granted $90.00 worth of food stamps and a six month spent down medicaid card. Every six month the family is cut off medicaid until I spend $258.00 in medical bills. My medicines alone is estimated at $199.00 a month. Thats not counting the doctor bills for myself and the children. I would like to know if there is anyway I could get a continous medicaid card, because if any medical emergency should occur during the time that we are not cover by any insurance, I don't know what would happen. The children get $592.00 a month. Which I live out of that money as well as the children.

Thank You Kindly
Betty Henderson
17134 Fenmore
Detroit Michigan
48235

19604 N. Highlite Dr.
Mt. Clemens MI 48043

June 29, 1989

U.S. Senator
Donald W. Riegle, Jr.
Century Center Bldg., 3rd Floor
30800 Van Dyke
Warren MI 48093

Dear Senator Riegle:

I'm afraid I received your letter inviting me to come to your meeting at St. John's Armenian Hall a little late. I arrived yesterday from abroad. I certainly would have attended since this problem affects me.

I live in Barcelona, Spain but still have strong ties to the Michigan area. I'm an absentee voter and I pay state income tax. I spend 3-4 months a year here but I don't work here at present. In Spain I am covered by a National Health Plan but when I come to the States it is invalid because the U.S. and Spain have no agreement or treaty which allows such reciprocality. I pay for HAP through Henry Ford Hospital when I am here but I must re-apply twice a year and cancel before I leave to return to Spain. Just this month, through a bureaucratic mix-up on their part, I had no coverage for the month of June. They insisted that there was a U.S. residency requirement, which I had never heard of and had never affected me before. In the end, I have coverage for July - August but then the whole process starts again in November when I have to re-apply.

Perhaps my case now is exceptional but before I moved abroad I was working part-time in 3 different places at the same time (what foreign language teachers in this state are reduced to, but that's another story) and was covered by no medical insurance plan in any of the places. I had to pay for my own health insurance when I wasn't even earning more than $10,000 a year.

Fortunately I'm healthy and still young enough not to have to worry about major illnesses. But any emergency still threatens to wipe me out financially. I hope you are able to do something about this situation. Thank you for your continued service to the community.

Sincerely,

Margaret R. Ristagno

Elizabeth Hilprecht
16138 Beatrice, Apt. 6
Allen Park, MI 48101

JUNE 24, 1989

DONALD W. RIEGLE, JR.
1850 McNAMARA FED. BLDG.
477 MICHIGAN AVE.
DETROIT, MI 48226

DEAR MR. RIEGLE:

I WAS HOPING SOCIAL SECURITY RECIPIENTS WOULD BE ABLE TO "BUY" MEDICAID FOR A LOW MONTHLY PREMIUM AND GET THE SAME COVERAGE AS SSI AND GA OR ADC + ADF RECIPIENTS. THE PREMIUM COULD BE ADJUSTED ACCORDING TO THE SIZE OF THE MONTHLY SOCIAL SECURITY CHECK. THIS METHOD WOULD ELIMINATE THE CURRENT CUMBERSOME SIX-MONTH CALENDAR OF THE MEDICAID SPEND-DOWN PROGRAM IF A RECIPIENT [redacted] COULD BE REVIEWED YEARLY LIKE FOOD STAMPS RECIPIENTS. IT WOULD ALSO ELIMINATE THE BACK-BREAKING $400 DEDUCTIBLE ("SPEND-DOWN" FIGURE) THAT WE PEOPLE MUST PAY BEFORE WE CAN GET A FEW MONTHS' MEDICAID (IN SOME CASES, A FEW WEEKS' MEDICAID) BEFORE STARTING ALL OVER. (PLEASE SEE SAMPLE CALENDAR, ATTACHED.)

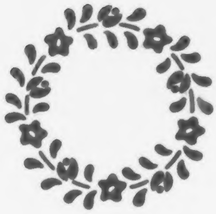
"BUYING INTO MEDICAID" WAS A CAMPAIGN IDEA OF PRESIDENT BUSH'S. LET'S NOT LET HIM FORGET IT, NOR LET HIM APPROVE A SLOPPY PROGRAM THAT GIVES PEOPLE LESSER COVERAGE FOR THEIR PREMIUMS THAN SSI, GA, ADC + ADF PEOPLE GET FOR NOTHING.

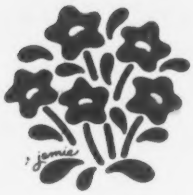
I HEARD THAT MICHIGAN RESIDENTS AREN'T SUPPOSED TO BE PAYING THE FULL $31.90 THAT'S BEING DEDUCTED EVERY MONTH FROM OUR SSA CHECKS AS OUR MEDICARE/PART B PREMIUMS, BECAUSE "CATASTROPHIC" ISN'T IN EFFECT HERE YET. ARE WE GOING TO GET A REBATE?

THANK YOU FOR YOUR LEADERSHIP AND CONCERN.

SINCERELY,

Elizabeth Hilprecht





SAMPLE MEDICAID SPEND-DOWN CALENDAR

A. DECEMBER (FOR EXAMPLE) — GO TO DSS, FILL OUT BOOK OF FORMS,
GET YOUR SPEND-DOWN FIGURE
(AROUND $400)

B. END OF JAN. - TAKE YOUR $400 BILLS + RECEIPTS TO DSS,
GET DENIED BECAUSE THEY RAISED YOUR
SPEND-DOWN FIGURE.

C. FEB. - GO TO DSS WITH ADDITIONAL BILLS AND
GET MEDICAID THRU 5/31

JUNE - START OVER!! (A, B, C PROCEDURES)

DEC. - START OVER AGAIN: A, B, C

JUNE - START OVER AGAIN: A, B, C

ETC.

COMMENT: IT'S HARD ON SICK PEOPLE
AND HARD ON THE DSS
WORKERS.

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Helen E. Hudson

Address 17540 Strathmoor
Detroit, Michigan 48235

Representing :

****

I invite you to attach a prepared statement or to submit your written testimony:

I, Helen E. Hudson, worked for the Detroit Board of Education for 13 yrs. In fact, I worked in the state of Michigan, as a teacher for a total of 27 yrs. I am covered with health insurance (as a retiree) through Blue Cross - Blue Shield. However, I have a son who is 35 years old who cannot obtain health insurance - anywhere. He has a college education but has not been fortunate enough to get a job with health insurance coverage. Right now, because of a store in which he was working went out of business, he is not even employed. I can not, as a retired widow, afford private insurance on him. If he gets sick, I don't know what I'll do. I worry about this problem daily.

Senator Don Riegle
Senate Finance Sub-committee Hearing
St. Johns Armenian Church Cultural Hall
22001 Northwestern Highway
Southfield, Michigan
Wednesday: June-28, 1989
10:00 A.M.

Hearing to focus on: Problems of Access To Health Care for uninsured individuals.

First, I would like thank Senator Riegle for holding a hearing such a this. It should be very valuable to the planning of a National Health Care for all Americans. Again Senator Riegle thank You.

a friend of mine Uninsured: High-Risk – uninsurable due to having the Hard Measles at age 5 and developed Hearing Loss and has seizures. While parents carry Life Insurance on her with them Beneficiary. That same Insurance Company will only insure at very high rates. Her Income cannot begin to pay such high rates.

My friend has worked since 19 yrs of age (now 37) and joined the Work Study Program at Wastenaw Community College – Completed 2 semesters in Restaurant, Proof Reading and Child Care.

She is now employed at a Burger King and has been there 7 years – A new company has bought out several Burger King restaurants, leaving a Complete Change over of benefits and several other changes that go with a new owner & employer. (Burger King where my friend works happens to be one the new Turnover or buyout, whatever.

Work related Insurance is all the insurance she has.

She is ineligible for Medicaid due Amount of Income – She is married – so There's 2 income in their household.

In this change-over the waiting period is 6 Months – I believe 3 month was what it had been in the past.

2 In my working years I have come to realize the Change from one work place to another can have serious set backs in respect to one's income to carry over expense during this process. Health Care especially; let alone other living expenses.

I have reason to believe the above testimony shows that there are gaps that could be a part of why one may fall into being Uninsured - Temporarily and maybe altogether. I know that a good share of the time I was trying to better my working status into respect to my Family as well.

Thank you,
Sadie M. Huntley

C.C. State Senator Lana Pollack

Note: Uninsured in Michigan
Rep Perry Bullard - office
1986 - 1,025,767
11% - Children / young adults
1/3 - working
66% employed full time
1/3 - Non-working - Unemployed

IPS INSURANCE PLANNING SERVICE
WHERE PLANS FOR TOMORROW ARE MADE TODAY

DIVISION OF
BERNARD AGENCY
20361 MIDDLEBELT RD
P O BOX 52398
LIVONIA, MICHIGAN 48152
(313) 478-8122

July 7, 1989

Honorable Donald W. Riegle,
Chairman Senate Finance Subcommittee
700 Washington Square Bldg.
109 W. Michigan Avc.
Lansing, MI 48933

RE: Senate Finance Subcommittee
Meeting June 28, 1987 at 10:00 a.m.

Dear Mr. Riegle:

This is to be considered as part of the subcommittee hearing on access to health care which I attended in its entirety and submitted a testimony in writing at that hearing.

The difficulties that some people have in obtaining health care was heart rendering and appalling.

Arlene & David Dilloway

Problem & Comment: No person should have to obtain a divorce to receive the health care that the spouse requires.

Solution: Research the reason that this provision exists. Then alter it with an exception: An exception to this provision will take place when:
1.)
2.) List the situations that would be exempt.
3.)

Carole Renaud

Problem: Absolutely obsurd that she and her husband would have to give up their children to the state in order to obtain medical attention for them.

Solution: Once again, research the original reasons for this ruling. Then alter it with exceptions as shown above, so the parents would not have to give up their children.

Problem: Funding methods

Solution: Please refer to my other letter for possible funding methods.

Comments: At the hearing, much time was taken explaining to everyone that

that certain segments of our population cannot buy health insurance. There were numerous testimonies about and by people that were turned down by insurance companies. - - To my utter dismay, there was no insurance company representation, and in my opinion, this was a major shortfall in the entire hearing, and should border on a misrepresentation. I feel the public was misinformed through partial representation. Someone should have been at the hearing to explain why these people could not be covered.

The insurance companies are not refusing to insure people because they are sick, they are prevented from doing so because of the insurance code, and the very nature of insurance itself.

References; Quoting the Michigan Insurance Reference Manual, Section I, State Insurance Laws and Administrative Rules, "It is never proper to insure any risk of which it is known a loss will be certain. In fact, in many cases of litigation, courts have held an insurance contract to be void when it was established that the insured knew a loss would certainly occur. Even in life insurance, there is no coverage against a certain loss since it is not a question of whether the individual will die, but rather when he might die."

Quote from: Law & The Life Insurance Contract, Chapter I, page 1. Risk and Insurance. "The problem of economic loss. In simple terms and in its clearest role, insurance is a plan for dealing with the risk of economic loss resulting from the happening of a future contingent event. In fire insurance, the risk is the possibility that ones property may be destroyed by fire."

O.D. Dickerson, in his book entitled, "Health Insurance Chapter II Meeting Health Losses," page 24. "Risk is defined as an uncertainty." and Webster defines risk as, "A chance of injury or loss."

In all of the cases cited in your Senate hearing, there was no risk when the insurance was applied for. The loss had already occurred. No one can insure a car after it is damaged by a wreck, and no company can insure a home after it is destroyed by fire because there is no risk. An insurance company is designed to absorb the "risk."

Solution; We need to set up a Sinking Fund from which to draw from when a person faces such hardships as were brought out at your hearing.

We need to change the constraining rules of Medicaid and Medicare to meet these needs and set up a funding program to handle these matters. (My other written testimoney gave a possible solution for funding these situations.)

It is not prudent judgement to change the principals that make insurance companies function.

Sincerely yours,

Robert C Bernard

Robert C. Bernard

RCB:njb
cc: Carl D. Pursell, Congressman
enclosure - June 27th letter (copy)

IPS **INSURANCE PLANNING SERVICE**
WHERE PLANS FOR TOMORROW ARE MADE TODAY

DIVISION OF
BERNARD AGENCY

20361 MIDDLEBELT RD.
P. O. BOX 52398
LIVONIA, MICHIGAN 48152
(313) 478-8122

June 27, 1989

Honorable Donald W. Riegle,
Chairman
Senate Finance Subcommittee
700 Washington Square Bldg.
109 W. Michigan Ave.
Lansing, MI 48933

Dear Mr. Riegle:

I am deeply honored to take whatever part necessary to assist you in resolving some of the health care issues that confront our State and our Nation. The issues are indeed very complex and are not easily addressed.

The following format will be compiled in such a way as to address a problem, and then a possible solution to that problem. The issues are not listed in order of importance. They are all important.

PROBLEM: Gap for spouse of retired worker.
Retired worker age 65 enrolled in the Medicare program. His spouse maybe age 60, and may have an uninsurable health problem. (Heart, diabetic condition, etc.) Spouse may be without insurance until reaching age 65 when she would be eligible for Medicare.

POSSIBLE SOLUTION: If spouse is uninsurable, and can present 2 declines from two commercial insurance carriers (this would prevent abuse of system), allow her to purchase at her expense, 100% of Medicare parts A & B. If a person qualifies for Medicare, then they can have a Medicare Supplement issued through a commercial company. Between Medicare and a Medicare Supplement, the person would have acceptable coverage.

PROBLEM: Section 89 and the termination of group coverages.
Employers are beginning to terminate their group plans because of the complexities of Section 89. While the original thought was to spread insurance to more employees, and be equitable in doing so, it has caused the small employer to seek administrative relief. In frustration, he terminates the plan for his employees.

POSSIBLE SOLUTION: Repeal or modify Section 89. It is so complicated that the average employer needs a CPA to test his group plan, and in some cases completely revise the plan to bring it into compliance. It is also creating an additional financial burden because the employer must cover part time help.

POSSIBLE SOLUTION II: Exempt small employers with less than 50 employees. Some smaller property and casualty companies are exempt from the Michigan Essential Insurance Act, due to size. A similar rule could be applied here.

PROBLEM: High cost of major medical insurance to consumer. This makes acquisition almost prohibitive in some cases due to pricing.

POSSIBLE SOLUTION: Tax relief in the form of deducting the full cost of any form of hospital, medical surgical and major medical insurance. This would help the consumer offset his expenditure.

PROBLEM: Persons that are uninsurable and cannot qualify for medical major medical insurance.
This segment is growing, not just because of Aids or medical reasons, but because the insurance companies cannot afford the high costs. Many insurance carriers have tightened their underwriting requirements for survival. Blus Coss/Blue Shield now has health questions on their individual applications. The Blue Cross is no longer operating in the context of their original charter, and therefore, there is no place for people to go that are physically impared.

POSSIBLE SOLUTION: Open Medicare to these people, but on a controlled basis. Have them present two declines prior to entry. Allow them to pay the premium for part A & B, plus an administration charge. These people would then be able to provide for themselves a Medicare Supplement plan.

POSSIBLE SOLUTION # 2: Set up a State insurance plan for impaired risks. The program must be surcharged for the impairment to prevent the good risks from entering the pool. The plan could be marketed through the independent agent network. The agent could be reimbursed for his or her efforts and expenses with a level 10% commission. Regional state controlled claim centers would be needed with claims people to handle the calls, adjust and pay the claims.

PROBLEM: Indigent.
There are state funded plans like Medicaid that are necessary for the people who are truly in a hardship position. Some of these people can't work, others are able, but are down and out and need help.

POSSIBLE SOLUTION: The state has a lot of jobs for able people. They could work 5 or 10 hours a week to pay for their medical coverage. If unskilled, clean offices, cut grass, etc.

PROBLEM: Totally and permantly disabled persons:
These people require medical care, also, and should not be denied this protection. The cost however, is great.

POSSIBLE SOLUTION: A small medical tax on the head of each person payable at state income tax time. Perhaps as low as $2.00 per person; man, woman and child. This would buy them the right to Medicaid while they were working and able to pay. Restrict and control furture tax increases in this area.

PROBLEM: Reducing the high cost of protection to consumers. The insurance company is a mirror that reflects costs to the consumer. Illustration - If a person has broken glass and nails in the driveway and the family car gets a flat tire, you just don't keep patching holes in the tire. You get out the broom and make clean sweep. The Federal and State Government can no longer afford to patch tires. We need a clean sweep in several areas.

AREA'S IDENTIFIED:

1. Extreme exorbitant cost of some HI Tech. electronic and other equipment.

   Possible solution:
   A full investigation is needed into the underlying costs of equipment and supplies that are manufactured and sold to the hospitals and medical industries, doctor's offices, labs, etc. These costs are passed on to the consumer through insurance rates.

   Possible solution II:
   Due to the high cost of some diagnostic equipment, it is almost impossible for one hospital to be all things to all people. Perhaps a specialty area would be more appropriate. An example: The burn center at U.M. hospital. It may be necessary to dictate which hospitals will do certain procedures. This might reduce the duplicating cost of very expensive equipment.

2. Cost Shifting. With the D.R.G. schedules, the hospital can only keep the patient for a limited number of days. This is to prevent unnecessary utilization and has helped reduce costs. The insurance companies have invoked cost containment features and have required that certain procedures be done on an out patient basis.

   Possible problem: Costs are shifted to the out patient departments and prices have risen dramatically. Result: Cost containment is not working.

   Possible solution: Federal and/or state mandated caps on out patient charges similar to a D.R.G. schedule.

3. Standardizing of room and board rates: In a recent discussion with an insurance executive, I was astounded to learn that one hospital had 37 different negotiated room and board rates. Seems like a very unfair practice. Why should one insurance carrier be charged a different rate for a patient in the same room?

Possible solution: Mandate a law that hospitals can only charge one fixed rate for a room (semi private or private, etc). Set up a maximum rate, and impose a stiff fine for exceeding these limits.

4. Laboratories and diagnostic clinics:

   Problem: Doctors own or control and refer their patients to specific laboratories for diagnostic services. There is a conflict of interest between profit for the lab, and the medical necessity for the testing to be done. I have been told that there is considerable abuse in this area, and it is on the increase.

   Possible Solution: No doctor should own or have ownership in a lab and send his patients to that lab. After proper investigation, some controls should be inacted in this area.

5. Doctor's fees for surgery

   Problem: Some doctor's fees are exorbitant. More and more doctors are not accepting Medicare assignment. That is, they are charging more then Medicare allows.

   Possible solution: Put a cap on charges. Set up a national charge chart similar to the D.R.G. schedule. If a doctor exceeds those charges and is caught, impose a stiff fine. Use a National average reasonable & customary rate

This has been a lengthy discussion. Indeed complex, but these are the areas that I feel need to be addressed. It comes from many years in the insurance business.

Best regards,

Robert C. Bernard

RCB:njb

Dave Jacobson
MCR Plastics Inc.
2238 Star Court
Rochester Hills. Mi 48309

Dear Senator Reigle,

Thank-you for your invitation to attend the hearing on health scheduled for June 28, 1989. Although I cannot guarantee it, I will try my best to be there.

I also believe that health care should be an American right.

Although I do have coverage now, when our economy went bad 8 years ago I didn't. During that time, needed lung surgery for my wife would not be done and I had to use credit cards in order to have x-rays taken. It might also be interesting to note that I took one hospital to court for charging me 3 times more than what they charge Blue Cross for the same procedures. Who except the richest of Americans could afford a hospital stay without insurance?

Our company does provide good insurance to our employees, which up until recently was about 35 people. But for the first time in our 5 year history we had no choice other than to layoff these valuable employees.

The last two paragraphs have a common thread in that they are totally dependant on being employed. There should be no separating the combined effect of this and other mandated legislation on business. There is no question that it will cost jobs, only a disagreement on the number of.

Mr. Reigle, I have specific questions in regards to your letter.

Of the 2/3's figure cited, what is the ratio of working Americans without insurance versus their dependants?
Of these working Americans, how many have less than a high school education?

I hope that these questions can be answered and that the causes of this tragedy have been well thought out. If not, and we attack the effects instead, I fear that we will only lessen the opportunities of those Americans and fall further behind in our world position.

As already stated I believe that health insurance should be an American right, not just for those working. I also believe that if our government acted as a partner with business and was willing to make the tough decisions necessary, that these and any other problems could be solved.

Thank-you,

Dave Jacobson

Dave Jacobson

Jewish Family Service

SAMUEL LERNER, Executive Director
24123 GREENFIELD ROAD SOUTHFIELD, MICHIGAN 48075 (313) 559-1500

CHILD WELFARE LEAGUE OF AMERICA
FAMILY SERVICE ASSOCIATION OF AMERICA
ASSOCIATION OF JEWISH FAMILY
& CHILDREN S AGENCIES
• • •
BENEFICIARY OF
UNITED FOUNDATION
JEWISH WELFARE FEDERATION

July 7, 1989

The Honorable Donald Riegle, Jr.
United States Senate
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, MI 48228

Dear Senator Riegle:

Although we were unable to attend the Senate Subcommittee on Health hearing of June 28 concerning access to health care for the uninsured, please be assured that we are heartened by your efforts to extend access to adequate health care to the poor, disabled and indigent.

From our experience administering a very modest poverty program to supplement the incomes of indigent Jewish persons for nearly two decades, we know that health care access is often the key factor for persons attempting to escape poverty. Time and time again, we have seen families fall into the welfare system or return to it because it guarantees access to Medicaid. We cannot point to a single documented instance where a wage earner family was able to access Medicaid, even though we have known several scores of such families which clearly met the income and asset requirements of the Medicaid "spenddown" program. Nor have our advocacy efforts to help such families establish eligibility for Medicaid ever been successful. We believe these are two essential reasons for this:

1. The welfare/Medicaid system is available 9:00-5:00 on weekdays only. This means that low-income wage earners must take time from work to apply. Most often this time is not compensated and many employers will not make time available.

2. The Medicaid "spenddown" program requires clients to keep receipts for medical expenditures for six-month periods before they can be processed for reimbursement. This hits hard in two ways. Low-income wage earners often have no time, energy or skills to negotiate the kind of record keeping involved to submit claims over six-month periods. If this were not a large enough impediment, medical facilities and personnel are not going to wait six months for payment and the low-income wage earner has no reserves from which to make payment. Anyone with that kind of money would be ineligible for Medicaid.

Our suggestion is that the Medicaid "spenddown" (protected income) program be scrapped in favor of an insurance system as a means of access to health care for the working poor.

If this cannot be accomplished, Medicaid "spenddown" should be redesigned so that providers would bill Medicaid directly and Medicaid office facilities should have some non-traditional hours available to wage earners.

Please be assured of our continued support of your efforts in this area and warmest personal regards.

Sincerely yours,

Al O

Alan D. Goodman
Executive Director

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: John F. Johnston

Address 28225 Delton, Madison Hts, Mi, 48071

Representing : Self

****

I invite you to attach a prepared statement or to submit your written testimony:

For The Committee.

There is, in my personal experience, a company — Taco Bell Restaurants — a div of PepsiCo. — where the management employees hold health coverage benefits, but, the part-time & full-time hourly wage employees hold absolutely no health coverage whatsoever. None. These employees can not afford to have such coverage deducted from their paychecks. So, if an accident occurs in the workplace, the employees are out of luck & on their own to finance their health care which for their tax bracket, is unaffordable. Sen. Riegle is correct to say it is a moral imperative to find a solution to this problem.

Gratefully Yours,
John F. Johnston

Dated: 6-28-89

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: Phyllis Johnson

Address 1151 Taylor, Rm 1126C
Detroit, MI 48202

Representing : Detroit/Wayne County Infant Health Promotion Coalition

****

I invite you to attach a prepared statement or to submit your written testimony:

I respectfully submit this testimony in behalf of high-risk women and children who reside in Detroit and Wayne county. While the State of Michigan is fortunate to be participating in the new Medicaid program for pregnant women 185% of poverty; we still have not been able to address the needs of the underinsured or "working poor". The lack of insurance or money has been verified to be the major obstacle for women who are pregnant and need prenatal care. The ability to access prenatal care is the most critical element of Infant mortality prevention and positive pregnancy outcomes.

June 27, 1989

Dear Senator Riegle:

After reading your letter dated June 8, 1989, concerning health care for uninsured individuals, I was very dismayed. Dismayed because I feel that not only should that be addressed, but also adequate health care and affordable premiums for the self employeds of our country.

My husband is a self employed barber and we are members of Blue Care Network. BCN has, in the last year up their premiums two times so that starting in July 1st we will be paying $340.00 per month for health care coverage. This coverage is being based on age and sex of [illegible] individual, which I feel is very prejudicial towards females, since there premiums are higher for a female in the same age bracket as a male.

Everyone, I feel, would like to be free of and not have to worry about things such as heart disease, cancer, aids or other uncurable diseases, but such is not the case. It is a fact that disease is here and some seem to be uncurable. As people of this country it is our job to protect our environment by protesting that we are being taken advantage of for the sake of making someone a millionaire or billionaire at the sake of our health.

We have govenment agencies that are being paid to help protect us, but it seems to me that they are doing a very, very poor job.

Thanks for listening to one who's very frustrated and dismayed concerning ~~health~~ health care for all Americans.

Vallory Johnson
147 Farrand Park
Highland Park, MI
48203

Dear Senator Riegle Jr.: 6/24/89

Because of the difficulty with health and transportation problems, I will be unable to attend the hearing by the Senate Finance Subcomittee on Health on Wednesday.

I have a matter of urgency, and would appreciate my comments being included in the official transcripts of this hearing.

I am a handicapped woman with two children, was severely abused in my marriage; forced to divorce because of the violence of my former husband; and deprived of medical coverage and alimony because of error on the part of my legal representation. The legal representation, though, at fault, refuses to correct their error.

I worked for the government, as a dedicated employee, for 4 years, but because of severe illness, caused from harassment from one of the government branches, I have been disabled from work for the last 2 1/2 years, and, again my family and I have been deprived of medical coverage all this time.

I think the government should offer a special coverage for people who are in similar circumstances — (Disabled, able to work occasional, limited hours or part-time hours) for a long time-period of waiting, until they finally do receive income from their claims.

Although I will include my name and address; I would appreciate my name remaining anonymous (and address) if my comments are read at this hearing.

I would also appreciate any help with my circumstances.

Sincerely,

Chris Karaczewski
19221 Connecticut
Roseville, Mi 48066

①

7/3/89

Dear Senator Riegle:

Enclosed is a piece of literature I received from your office on June 29, 1989. This was the day after this meeting was held.

I would have been very interested in this meeting because my insurance is going to lapse at the end of this year. At the present time I am appealing a decision made by the U. S. Railroad Retirement Board in Chicago, Il. This is in order that I may come under medicare.

I have worked for 23 years as a yard conductor for the New York Central R.R., the Penn.

Central R.R., & the Consolidated Rail Corp. In the last few years of work I devoloped arthritis in both of my knees rendering me unable to work because of the swelling of my knees, the pain, & the loss of strength in my legs. I applied for and received a medical disability from the R.R. The railroad is a closed shop & my seniority is not transferable to any other department and besides I can not work indoors because I have agorophobia for which I am now doctoring at Henry Ford Hospital. Another reason I need your help is that a doctor at H.F. Hosp. told me that I am probably uninsurable.

③

The reasons for me being unemployable are as follows:
I have a hiatial hernia which is service connected & I get antacid medicine from the V.A. Hospital.
I have arthritis in both knees for which I take 2 Voltaren pills a day, high blood pressure which I take Corgard, diabetes which I take Micronase, and agoraphobia which I take Xanax every day.

Due to the fact that I get a small disability payment & I am restricted from work or otherwise making a certain amount of money. I also have my age against me as I am 58 years old, and if I get employment, which I am not sure I could keep, I loose my disability.

(4)

The reason I got this arthritis was because of the terrible work conditions at the railroad. This is the reason I had to have an operation on my right knee (to remove 3 very large joint mice) on Aug. 5, 1986.

I would appreciate any help you can get for me concerning this health care issue.

Sincerely yours,

Thomas Kavanaugh
5924 Evangeline
Htn. Hts., Mich. 48127

P.S. Enclosed is a letter I received from the R.R. Board in Chicago denying me medicare.

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
844 RUSH STREET
CHICAGO, ILLINOIS 60611

BUREAU OF RETIREMENT CLAIMS

APR 14 1989

Mr. Thomas F. Kavanaugh
5924 Evangeline
Dearborn Heights, Michigan 48127

In reply refer to
R.R.B. No. A 374-36-3461

Dear Mr. Kavanaugh:

This refers to your letter requesting reconsideration of the denial of a period of disability.

We have again carefully reviewed all of the medical evidence in your file and are still of the opinion that you are not disabled for all regular work.

The medical evidence shows that you have arthritis of both knees and suffer from agoraphobia. There is no limitation of motion in your knees but there is intermittent effusion. Your agoraphobia slightly limits your activities of daily living and social functioning but is not considered severe enough to prevent all work. Based on the objective findings, your impairments would limit you to light work activity but should not prevent all regular work.

If you disagree with this decision, you have the right to appeal to the Bureau of Hearings and Appeals. If an appeal is made, it must be submitted on Form HA-1 and must be received at an office of the Board within 60 days from the date of this notice. Form HA-1 is available at any office of the Board.

If you have any questions about this letter, contact the nearest district office of the Board. If you call in person, bring this letter and any other material about your claim with you. Most Railroad Retirement Board offices are open to the public from 9:00 a.m. to 3:30 p.m. Monday through Friday.

Very truly yours,

Robert S. Kaufman

Robert S. Kaufman
Director of Retirement Claims

KLAVER AGENCY
Affiliated with
Crawford Insurance Agency
346 E. State St.
Traverse City, MI 49684
(616) 929-2688

June 23, 1989

Senator Donald Riegle Jr.
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, Michigan 48826

Dear Senator Riegle;

Thank you for the invitation to the hearing on health care you are holding in Southfield. I will not be able to attend, but, appreciate the opportunity to present my thoughts on the subject in writing.

Since 1982, my primary business is providing health insurance coverage for small businesses, generally under twenty employees. These include many self-employed individuals as well as employers. All have major concerns about the cost of health insurance coverage as well as the actual cost of the health care itself. I have heard many ideas on the subject. The typical employer in this group with fifteen employees will spend $25,000.00 on a group health plan.

Unlike what we are reading in some news articles and is being touted by some of your contemporaries, very few health insurance carriers are making large profits. On the contrary, many have lost money over the past few years and some, such as Transamerica and Columbus Mutual, have gotten out of the health insurance business altogether.

There is a cause and effect here most employers understand, even though the average employee may not. Medical care in the United States is very expensive, therefore, the cost of insurance to cover that care is also expensive. This is not likely to change until some drastic, potentially politically unpopular action is taken to correct the problem at it's source.

Duplication of service amoung hospitals should be eliminated. Munson Medical Center in Traverse City is putting in a new open heart surgery unit and has a neo-natal care unit, among other specialty areas. Most of the same services are available at Northern Michigan Hospital in Petoskey. In an emergency situation, this is only a fifteen minute helicopter ride from Traverse City. This same situation is prevalent in many larger cities among local resident hospitals. What is needed is an incentive program to require hospitals to work together and, possibly, a disincentive program for hospitals installing equipment and services in specialty areas that are already available locally. These programs could be set up through tax incentives or disincentives or through the withdrawl of Federally funded programs from hospitals that will not co-operate.

We are not going to change a physician's lifestyle or income, thus, attempting to put ceilings on fees is not an answer. However, a major portion of those fees is malpractice insurance premium and many, if not most, tests required by physicians are simply done to avoid malpractice suits. There has to be some way to limit these costs. One method would be a type of "no-fault" legislation, such as we have for car insurance in Michigan. Another is to put a cap on award damages. Neither of these would be popular and would stand little chance of passing into law. Perhaps a more feasible approach would be to require the losing party in such a suit to pay for all costs arising out of the suit. If an individual knows he or she could have considerable expense in the event of a loss, that person may not be quite so quick to file a frivolous lawsuit. Another alternative would be legislation defining a strict interpretation of liability and requiring proof of "gross negligence" on the part of a physician in order for a suit to be successful. Coupled with this legislation, would have to be a bill regulating "windfall profits" to physicians and hospitals to lower fees at the same percentage as the decrease in malpractice premiums.

The major problem I see in the above recommendation is not in getting an intelligent bill written, but, in finding enough legislators in both houses with the intestinal fortitude to stand up to the ATLA and the AMA to get the legislation passed.

These ideas have addressed attempts to lower the cost of health care and insurance costs, but, not the plight of those who are unemployed or work for employers who do not furnish health insurance. (As for the latter, I firmly believe any attempt to force all employers to furnish health insurance, at this point, will result in a large number of small companies going out of business and higher unemployment, particularly in the lower wage groups.) One answer to this problem might be the establishment of federally or state run hospitals and clinics similar to the V.A. hospitals now in existance to furnish health care to only those not covered through insurance plans and who do not have the means to pay for health care through normal channels. To help alleviate some of the cost, physicians and nurses employed in these units would have to be protected by very restrictive malpractice legislation. It is agreed this would be a very expensive proposition. However, if congress would take steps to eliminate the waste in other areas of the government, part of the cost would come from that. The rest may have to be made up through increased taxes. I know this is politically unpopular and a very touchy issue, but, the American people are going to have to pay for these services one way or another. Perhaps it is time for them to come to that realization. We have literally priced some of our citizens out of existance.

The key to any solutions in the area of medical treatment and cost reform in this country is a solid core of legislators with enough backbone to stand up to the special interest groups that are causing the problems in the area and to fight for proper legislation to correct it.

Thank you for allowing me to air my views and ideas. I would be pleased to be able to meet with you or a member of your staff to discuss this problem in greater detail.

Regards,

Grant M. Klaver

Grant M. Klaver

Senator Donald W. Reigle, Jr.
705 Washington Square Building
109 W. Michigan Ave.,
Lansing, MI 48933

June 15, 1989

Dear Senator Reigle:

Because I will be in northern Michigan on June 28, I am taking this opportuhity to write you regarding issues affecting health care. As you so aptly state in your letter of June 10, 1989, "... I (too) believe high quality, affordable health care should be available to all Americans and their families." And, I hasten to add, families eligible for Medicaid are often among those most inadequately provided with quality care.

I fear, however, increased federal government mandates. As you are undoubtedly aware, demand responds to fill availability, regardless of actuarial experience. If a clear definition of the population most specifically in need of expanded health care services can be brought to a consensus, that population should receive the first attention. Among segments of the U.S. population that may be most in need of health care services are:

Children
Children of children (Teenage parents)
Single parents with children
Working poor (especially the younger working poor)
Aged - Although most statistics refer to the elderly, it is
  the elderly elderly (those over the age of 85) who
  appear most in need. This is why I've used the term 'Aged.'
Disabled

Each of these categories may be further divided simply by femanizing them. That is, wherever the woman is the responsible person for providing economic support, there is a high probability that income is inadequate to cover health care services--and many other services as well.

Among all of the information you will be called upon to weigh as you hold these hearings in various locations and as you receive comments such as these, I hope you may be prevailed upon to request an analysis by your staff of a funding mechanism that is least harmful to those most in need. For example, in a large segment of the working poor, Social Security taxes represent a major cost that could, when combined with the employers' match go far towards providing a basic health care insurance.

It seems somewhat counterproductive to impose Social Security or any other taxes upon individuals who's income is barely at or often below a governmentally defined poverty level--then, in turn, to subsidize the individuals by way of some other mechanism that is frustrating to the participants, requires inordinate detailed and time consuming form filling, and imposes restrictions and sanctions that often appear to be arbitrary, capricious or downright rediculous. Would it be possible to do two things? First, recognize that poverty levels, although varying among states, represent real hardships then embodying into federal legislation relief from all federal, state and local taxes for the working poor up to this level. Second, use the Social Security taxes from the working poor to the poverty level as premiums (from both the employer and the employee) towards health coverage.

June 15, 1989, Senator Reigle - Comments re: Health Care Services - page 2

This second action would provide the working poor with a direct investment in health care services. In addition, further funds could be provided by imposing the Social Security taxes on all earned income and applying these amounts from the increased Social Security taxes on the earned towards further premiums to benefit all of the categories in need of health care services.

Finally, building upon the HMO concept, every hospital, as a condition for that hospital to exist and provide any health care services, would be assigned a proportionate number of those individuals identified as most in need of health care services and be categorically required to provide health care services to them. Such an approach should increase wellness activity, clinics and perhaps some return to the visiting nurse concept so effectively used during the Depression.

Would such approaches provide an ultimate solution? I rather doubt they would fulfill all of the competing needs. Nevertheless, some such innovative approaches in conjunction with other funding sources and service provisions should be considered. We presently impose a tremenduous psychological and social barrier to achieving independence by requiring those least able, to shoulder the imposing burden of taxation on incomes below poverty--disproportionate to their ability to pay.

I apologize for a too lengthy letter. It is distilled from several pages of personal frustration at a system that appears to deny services to the needy while at the same time providing gold-plate for others. If I can be of assistance, please do not hesitate to call upon me.

Sincerely,

PM Lamb

Paul M. Lamb
229 Hoehn Court, Box 117
Dimondale, MI 48821-0117

Marilyn Leach
7673 Mortenview
Taylor, Mich. 48180
(313) 295-4845

Dear Senator Riegle,

Last October I wrote a letter to my Congressman, William Ford, concerning Health Care insurance. I seem to be in a group that has no group insurance available to them. In 1984 my husband was seriously injured in an accident at work. In 1985, after spinal surgery, which was covered by insurance, He was told by his doctors that he wouldn't be able to work again. He retired and began receiving social security, and in 1987 began receiving Medicare Insurance and was also eligible to buy

2

more insurance Coverage With Health Alliance Plan of Michigan. As I am his dependant I was told that I Could also apply for insurance along With him. The cost of this would be $70.00 per mo. for my husband and about $125.00 per mo. for myself.

Because my husband was receiving medicare he was automatically accepted With H.A.P., but my request for insurance was denied Without explaination. I should tell you that my husband is 53 yrs old and I am 50 yrs. old and a long way from medicare Coverage.

Last year my husband had a heart attack. His bill for 9 days in the hospital was $4000.00 His medicare insurance thankfully, Covered all but $500.00

3

If I had been the one that had to be in the hospital, I don't know what we would have done.

It scares me to even think about becoming ill. Except for having our Children, I have been hospitalized twice in my adult life, both times for five days and neither time was for a serious illness. My doctor was surprised that I was denied insurance because I am in good health. When I wrote to my Congressman I used the very words that you did in your letter "affordable quality Health Care", I don't want a free ride, I just want to be able to buy good insurance that I can afford. I know that there must be many women and children who are dependents of disabled workers who receive social security, but no insurance for their families. I also know that my situation is only a small part of a health care system that doesn't come close to meeting the needs of a great many americans. Our government should be ashamed of the poor health care statistics that are published every year with no solution in sight.

Senator Riegle I hope that your subcommittee can change this problem. I am willing to pay my share for a better health care system for everyone. I would like to believe that most americans feel the same way.

Needless to say, I will be following your progress with great interest.

Sincerely,
Marilyn C. Leach

7758 Stout
Detroit, Michigan 48228
June 28, 1989

Re: Senate Finance Subcommittee Hearing
Accessibility of Health Care for the Uninsured

The reason for my presence here today is for all of those who have been hurt as well as for myself who have been victimized by a system where health care needs are used as a wedge for deceptive employment practices.

The need for quality medical care for all is a right that should be guaranteed for all and no one disputes that in principle. In reality, however, it seems that adequate health care needs has been addressed to some extent for all except for the "working poor." These are individuals who are employed where there are no health care benefits or those employed on a part-time basis. I do not have the answer as to how one can educate employers that in providing basic health insurance for their employees is in their best interests as well as their employee's best interest but I do know the deleterious effects of non-coverage and the only way I can do that is to relay what has happened to me.

I am a 36 year old woman who has worked her entire life. I recall my second job where health insurance was not provided (this was over 15 years ago) and it seems the situation has not changed drastically since that time. I was eventually successful in getting my employer to provide basic health insurance for their employees and since that time the majority of the positions I have held have provided medical insurance for their employees, however, not without sacrifice and risk by their employees.

I can recall the time when discrimination in health care was the standard practice, being hospitalized for a condition that was only covered if there was spousal coverage as well. I know the anxiety and embarrassment of dealing with an insurance company who denied coverage for a woman for any condition dealing with pregnancy and childbirth.

Since that time and that is a very long time ago I had taken a position where the employer refused to pay for their employees coverage even though I was told "We could pay for your medical insurance but it would only make the hole a little smaller and not cure the problem." Hence, do nothing - its your responsibility not mine or of an employer who was aware of the problems of their new employees in gambling on new medical coverage where there is waiting periods for pre-existing conditions not taking into consideration the fact that an employee only wants to be assured of medical coverage should that previous cancer condition which was successfully treated as an example or any other condition that was treated successfully in the past but just might crop up again.

Therefore the only alternative left for me as for many others is Blue Cross and Blue Shield of Michigan that does not discriminate as far as its coverage for those who do not have insurance elsewhere, however, they too are not without capriciousness. Their rates are exorbitant to say the least and as I understand are requesting and given their past history will probably be granted another rate increase in October. When I first obtained Blue Cross there of course was a clause for pre-existing conditions and I was told by them when I inquired as to what type of coverage I indeed had, was told "For six months (the time period for pre-existing conditions) the only condition I would be covered for is an injury due to an accident, virtually everything else would be considered pre-existing by us." Real assurance for one who only wants to be guaranteed the right to decent medical care.

It is no secret to anyone who has ever sought medical, psychological or dental care that the first question one is asked is "Do you have insurance?" "Will your insurance company for this?" which often becomes the deciding factor in the care an individual receives. It seems the health care professions are much more interested in economics than the profession they were trained for or any oaths that they took germane to their profession.

In addition, when an individual becomes unemployed through lay-off or any other factors, there is now a law (ERISA) which guarantees that employee's right to maintain their own insurance that they previously had for certain lengths of time, at the ex-employee's own expense which many cannot afford and often is a discounted benefit. For example, an employee who had worked for the City of Detroit which maintains a dental benefit, becomes retired, that dental benefit no longer exists. There is no agency that I am aware of that makes a provision to reimburse the medical insurance benefits an employee had previously.

It seems that the only way to secure a guaranteed medical insurance benefit if not covered by an employee or spouse is to become totally indigent - therefore becoming a burden upon society as a whole, wherein if employers were required to maintain coverage for their employees on a federal level perhaps those who can work and are not able to work due to lay-off, family demands or any other non-medical reasons might be encouraged to re-enter the work force as opposed to becoming a burden on society as a whole.

It is interesting to note and it has been my experience as well as many of those I have spoken to, that employers who do not maintain health insurance benefits for their employees are those who are very often in violation of OSHA standards and exhibit a general disregard for the safety of their employees, generally maintain a level of anti-government attitudes and share the prevailing attitude of the government has no right to intrude in my precious domain (the employer's workplace). These employers usually rely on worker's compensation laws for protection as their is no economic disadvantage to them as well as for Social Security protection - using the government as protection only when it is in their economic interests.

There are so many of us who have been victimized by a society who turns its back on those who have had medical treatment in the past, have changed jobs or whose lives have been disrupted for one reason or another but it seems the bottom line is that most people would like to contribute to society regardless of what limitations they have or what accomodations are needed and what indeed have we become if we do not value the health care needs of our society, where adequate medical coverage is a bargaining tool by a health care system that puts profits before the quality of care we all deserve.

Sincerely,

Jacqueline G. Lewicki

Jacqueline G. Lewicki

July 6, 1989

Dear Mr. Riegle,

I was very interested in your notice of the hearing on June 28 for uninsured individuals. Problem was I received notice on July 5. I would have attended, had I known in time.

My 30 year old daughter was awarded Social Security disability on June 10, 1989 - First payment will come in October then we wait 24 months for Medicare to start. We are wondering what options are available befor the medicare + even after. Her income has been established at $646.00 monthly.

Her employer is making her B.C. ins. coverage available for her to purchase at 102% for 18 months due to the COBRA act. She is collecting a disability ins. from work amounting to 163.00 weekly through February of 90 ......
which I would imagine would not qualify her to apply for Medicaid till that has run out, in February.

My daughters condition that

disables her from work is many complications due to diabetes.

Her hospital stays at University of Michigan Hosp. are frequent.

Her medications are numerous.

Her Dr visits are very costly. I can't imagine any insurance Co. being willing to cover her.

As chairman of the Senate Finance Subcommittee on health for uninsured persons I'm hoping that you could provide me with any thoughts you may have on insurance coverage for her. We are not sure where to turn. We would greatly appreciate any and all information you could provide us with.

Thanking you in advance for your co-operation in our need. This is a very scarey step for us — into a very new and unexplored area! We feel so ignorant and uninformed!

Carol Leyme
32743 Fairchild
Westland, Mi. 48185

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Matt Linn

Address 1151 Taylor, Det. Mi. 48202 Blg. 6.

Representing : Det. Health Dept. (Senior Citizen's Health Screening)

****

I invite you to attach a prepared statement or to submit your written testimony:

Systems That are in place for Those who ~~That~~ are under insured or not insured need To be more accessable, such as ~~Th~~ The Det. Health Dept. Clinics which most people aren't aware of. For instance medication is free To all of our clients.

LENAWEE COUNTY HEALTH DEPARTMENT
1301 NORTH MAIN STREET
ADRIAN, MICHIGAN
49221

June 20, 1989

Senator Donald W. Riegle, Jr.
United States Senate
Wayne-Monroe
1850 McNamera Federal Bldg.
477 Michigan Avenue
Detroit, Michigan 48226

Dear Senator Riegle:

This letter is my written testimony to the Senate Finance Subcommittee regarding the access of health care for the uninsured individuals. As health officer I am exposed to the front line effects of lack of health care in our community. I have witnessed a dramatic increase in the use of public health clinics for family planning, immunizations and crippled children. I also serve on a local committee of private, public, and volunteer health care providers exploring methods to address the problem of inadequate health care for the unemployed and underemployed locally.

My specific recommendations to address this problem are:

1. Increase funding for prevention programs for persons that are above the "poverty line" which would include the underemployed. Types of programs needed are:
    a. Family planning
    b. Well baby clinics
    c. Geratic clinics
    d. Health Promotion in the work place (weight, blood pressure, eye exams, dental care, etc.)
    e. Funds for health education and promotion for local health departments.
    f. Health Education and Promotion in day care and schools.
2. More local control and administration is needed of federal grants. Too often rural health departments do not apply for federal or state grants because of the impossibility to conform to needed documentation and other paper work.
3. Federal Health Insurance with a high deductible for all persons.

Federal Health insurance would be only a tourniquet if health education and promotion are not an integral part of a *health revolution*.

Sincerely,

Frederick L. Keesla

Frederick L. Keeslar, R.S., M.S.P.H.
Health Officer

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: ~~Anonymous~~ Matt Linn M.S.W.

Address Detroit citizen.

Representing : My self

****

I invite you to attach a prepared statement or to submit your written testimony:

When the Canadian system was developed alot of doctors, hospitals, and insurance companies had To make major comprimizes. How do you propose To To get the heads of our Medical (For profit) ~~Hier~~ Hierarchie To make these comprimizes? Who is going To get BC/BS, Medicare + Medicaid To look at comprehensive health as Preventitive in Nature?

June 30, 1989

Dear Donald W. Riegle, Jr.

We received your letter inviting us to give our Testimony on health care for uninsured people, unfortunatly it arrived a day late for the Southfield Michigan hearing. I would like to submit this letter as testimony to our problem.

My husband lost his job in Dec. 1988 due to questionable circumstances. Of course we were very upset, one of our main concerns were medical coverage for the family which unemployment don't cover. Well we were even denied unemployent and still are fighting for something we paid for and feel we are entitled to. We filed for assistance through Michigan Social Services to get help for our family, it was a hard fight and ther was the month of January and part of February we lived on $20.00 a week. I had to call Jerry Bartnik officeto see what they could do for us, a couple days later we had a new case worker and a week later we had food, money for bills, and most of all we had some medical coverage. We would like to thank the State for their help during these trying times.

Now, we are faced with the dilema of no insurance again, we knew when income tax refunds came back we wouldn't get no assistance from the state so my husband took a job paying half of what he earned at his previous employment and no benefits for 3-4 months to come, if they keep him full time permanent. I'm sure theres many people having this problem or maybe on assistance and offered a job at $5.00 $6.00 per hour but are concerned about health care insurance so they stay on assistance because it covers the basic needs, of food, shelter costs and formost health care cost which are out of control. As you may or may not know the first thing you get cut off of when you earn some income is medical assistance something you need or some places refuse medical help.

One proposal is that when a person or family is on assistance and offered an income that maybe able to support them but cannot afford the extra $100-300 for just hospitalization that the state charge a percentage of the persons monthly wages until the company covers its employee. This allows for families to get off public assistance and the states deficit maybe brought down to help the ones that cannot get employment due to physical problems not only that the money recieved for medical coverage can also help get the state [illegible] out of the red.

Example: lower percentage on basis of family size.

Family 5 income

6.00 ph. x 40 hrs 240 wkly x 4 = 960 Monthly income x .05 [illegible]% = $48.00

We now with my husbands wages $7.00 ph. are just bringing in what we were getting on public assistance.

Example: 330 x 2 = 660 check from Mi
224 food stamp
884
150 Electric + Gas Bills
This is total cash value $\boxed{1034}$
plus medical coverage and perscription.

This is great but the thing people look at when offered a job is medical benefits which really is not a benefit but a necessity.

As for those that go without insurance all the time a national or state run insurance program run on percentage basis of monthly income, family, size. This may force those insurance companies down with their rates. Also maybe put a freeze on doctors office rates, surgury rates and most of all hospital rates. If all this can be done almost simotaneously I think just about all can get good health coverage, and doctors, hospitals, and insurance companies can still get a profit also the State can and maybe even profit too. The way it looks to the working class now is that its the doctors, hospitals, insurance companies and yes even lawyers are running our government instead of the government listening to us the people and using some of our proposals to see if everyone can benefit from others peoples ideas. There has to be an end before too many innocent people die due to lack of insurance and medical help.

Thank you,
Sincerely
Vicky L Lintula
Barry E Lintula

MACOMB COUNTY HEALTH DEPARTMENT

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469-5372
ENVIRONMENTAL HEALTH
469-5236
PERSONAL HEALTH SERVICES
469-5520

43525 ELIZABETH
MOUNT CLEMENS, MICHIGAN 48043
(313) 469-5235

DANIEL C. LAFFERTY
Director/Health Officer
LELAND C. BROWN, M.D.
Medical Director

July 7, 1989

The Honorable Donald W. Riegle, Jr., Chairman
Senate Finance Subcommittee on Health for
Families and the Uninsured
477 Michigan Avenue
1850 McNamara Federal Building
Detroit, Michigan 48226

Dear Senator Riegle:

The opportunity to provide information concerning unmet health needs of our fellow citizens is appreciated. Community Health Nurses have their services on the "pulse of the community", providing basic yet critically needed services in homes, schools and community sites.

Over the past few years, there have been ever-increasing numbers of various unmet health needs of the people we serve. Access to care is becoming unavailable to ever-increasing numbers of people at every age level.

When some of our nursing staff became aware of the Federal Hearing of June 28th, they responded by writing specific personal observations, which are enclosed.

To my knowledge, there are currently no medical care facilities available to service families on a "sliding scale" fee in Macomb County. Facilities that did provide care to these people - low income, working, no benefits, no longer do provide the service. Our referral source for care at the time is William Beaumont Hospital Clinic in Royal Oak. In fact, it is at times difficult to get care for Medicaid patients.

The enclosed statements are bare minimum statements of concern representing a top sample of what is generally thought to be a very deep unmet need for many people - no medical care.

Thank you for your concern. We urge continued evaluation and defined program actions to respond to this situation.

Sincerely,

Joyce Burkhardt, Rnc

Joyce Burkhardt, R.N.C., B.S.N., Supervisor
Adolescent/Adult Health Division

eb

Attachments

MACOMB COUNTY HEALTH DEPARTMENT

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DANIEL C. LAFFERTY
Director/Health Officer

LELAND C. BROWN, M.D.
Medical Director

July 7, 1989

TO: SENATOR DONALD W. RIEGLE AND MEMBERS OF THE
SENATE FINANCE SUBCOMMITTEE ON HEALTH

On phone duty June 27, 1989

I received a call from a female, age 51, regarding present status of no insurance and very little money. Her husband has been laid off, and is now back to work, but no insurance for 90 days. She is diabetic and has other health concerns. Had episode of cellulitis of her leg. Was treated in the emergency room at Macomb Hospital on Friday or Saturday, 6-24-89. Was instructed to see physician on Monday. Doctor there gave her prescription to be filled. This she cannot afford. Has not had any of her medications renewed since last October because of no insurance and no money. Has called Department of Social Services - no help because married, husband working, has car and is buying home.

Jacqueline Gunst /c.s.
Jacqueline Gunst, R.N.C., B.S.N.

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DANIEL C. LAFFERTY
Director/Health Officer
LELAND C. BROWN, M.D.
Medical Director

July 5, 1989

The Honorable Donald W. Riegle, Jr., Chairman
State Finance Subcommittee on Health for
Families and the Uninsured
Wayne-Monroe Office
477 Michigan Avenue
1850 McNamara Federal Building
Detroit, Michigan 48226

Dear Senator Riegle:

The recognition of the seriousness of the problem of health care for the uninsured by the Senate Finance Subcommittee on Health for Families and the Uninsured is to be commended.

Upon becoming aware of the Subcommittee's hearing in Southfield on June 28th, several public health nurses of the Macomb County Health Department, on their own initiative, prepared the enclosed statements on this critical health care issue. Their comments though brief and anecdotal exemplify that health care services are indeed not available to a significant segment of the population. We in public health are most interested in working with governmental leaders such as yourself and other committee members toward assuring that high quality affordable health care be available to all citizens.

Sincerely,

D. Lafferty

Daniel C. Lafferty
Director/Health Officer

eb

Attachments

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DANIEL C. LAFFERTY
Director/Health Officer

LELAND C. BROWN, M.D.
Medical Director

July 7, 1989

TO: SENATOR DONALD RIEGLE AND MEMBERS OF THE
SENATE FINANCE SUBCOMMITTEE ON HEALTH

Women who have gynecological problems (uterine and breast), not related to family planning or pregnancy and have no health insurance, have difficulty finding low cost health care. Examples of clients we have serviced with this problem are:

1. A 27 year old woman having irregular uterine bleeding, nausea and vomiting with history of tubal ligation, needed testing to rule out tubal pregnancy. Her husband is working but they have four children, are low income and have no insurance and do not qualify for Medicaid. They moved to Michigan in the last year from Florida where they used low cost services through the Florida Health Department. Our County and State provide no low cost acute-care services for adults, nor assistance for surgical procedures. Local hospitals run out of Hill-Burton Funds in the first few months of the calendar year.

2. An 18 year old woman needing colposcopy and biopsy for abnormal pap smear. The county Family Planning Clinic did the pap smear, but does not provide other follow-up procedures.

A second concern is senior citizens (50-65 years old) who are not yet Medicare eligible. If they have retired without benefits, are widows or divorced women, they often have no insurance to cover them for preventative care or in acute illness. An example is a 63 year old female recently divorced who lost her health insurance benefits with the divorce. She is working at a job which doesn't offer benefits. She is hypertensive and has high cholesterol needing treatment. With her low income, she is having difficulty paying for doctor visits and medications. Another example is a 60 year old female without insurance who needs eye surgery. She doesn't qualify for Medicaid or Medicare.

Teens in areas without teen health clinics, and young adults with low paying jobs and not covered by their parent's insurance, call us requesting low cost acute care. Examples of care needs are emergency care in case of injury, broken bones and emergency surgeries.

For example, a 25 year old with gallbladder disease needing surgery has no insurance and a low paying job.

A 35 year old with cataracts has no insurance for surgery.

A 45 year old with hypertension has no insurance for check-ups and medications.

Clients of all ages call requesting low cost care for diagnosis and treatment for infectious diseases such as rash illness, Lyme Disease, ear infections, and diarrheal illnesses.

An example case is a family with a three year old suspected to have Lyme Disease. The family had no health insurance and could not afford the diagnostic workup and treatment for Lyme Disease. Infectious diseases are not covered by the State Crippled Childrens Program.

There are several alternative solutions in handling these needs:

-Provide acute and well care for all age groups at the local health department for families at 185-200% poverty level.

-Provide medication assistance for clients.

-Provide incentives for physicians and nurse practioners to treat low income clients at the 185-200% poverty level.

-Offer a voucher to clients to use with their private physicians similar to the pregnancy prenatal programs.

All of the above need funding through Federal and State governments.

Theresa Peters, RN
Theresa Peters, R.N.

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DANIEL C. LAFFERTY
Director/Health Officer

LELAND C. BROWN, M.D.
Medical Director

July 7, 1989

TO: SENATOR DONALD W. RIEGLE AND MEMBERS OF THE
SENATE FINANCE SUBCOMMITTEE ON HEALTH

I would like to share with you some of my concerns regarding health care. We have phone duty from 8:30 to 5:00 daily. Here is a typical four hour period that we experience daily.

Three of the phone calls were relating to lack of funds for medical care -

1. Young working family, no insurance coverage from job, critically sick infant; no funds to see a private physician.
2. Had limited funds to see a physician, but no money for prescriptions.
3. Forty three year old female - had problem with her legs, necessitating quitting her job - with no funds to see a physician.

It is also becoming increasingly more difficult for Medicaid families to seek care, particularly in this area.

Jane Murray, RN (FPB)
Jane Murray, R.N., B.S.N.

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MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES
ADULT DAY TREATMENT CENTERS

SOUTH
14777 Alvin
Warren, MI 48089
759-9100

NORTH
44350 Groesbeck Hwy.
Mt. Clemens, MI 48043
469-5974

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[illegible]

June 28, 1989

Senator Donald Riegle
1850 MacNamara Bldg.
477 Michigan Ave.
Detroit, MI 48226

RE: Written Testimony
Public Hearing on the Uninsured
Senate Finance Committee on Health

Our Agency, Partial Day Services, is part of Macomb County Community Mental Health. We are under the direct auspices of the Michigan Department of Mental Health, and the Macomb County Board of Commissioners. We are a public agency.

Our mission is to provide mental health services to the severely and chronically mentally ill adults in Macomb County. We have a total of seven different programs to provide a range of services to clients and families over the course of the illnesses.

As is the charge to all CMH agencies,we are to provide service without bias in any area, including ability to pay for that service. This is a charge we take very seriously.

The growing numbers of uninsured persons with severe mental illness is becoming alarming at the same point in time when more and more energy and resources are being used to attempt to collect fees and seek reimbursement from third party payors, particularly Medicaid. This sets up the CMH's in a strange double bind. "Serve the "medically indigent"". "Put total effort into reimbursable activities and documentation". All of this also occurs along with the always increasing demands for our services. Because we so frequently operate from a "waiting list", those persons with the most glaring needs get priority. Typically, this takes the form of admitting those without insurance, while suggesting those with coverage seek treatment elsewhere. This then continues to reduce the probability of collecting monies from insurance carriers. It also sets up a screening criteria that has nothing to do with clinical issues, or any needs or desires of the clients. It in effect, sets up a reverse of the original intent. We now have to screen out people who can pay for service, and send them elsewhere.

Because so many in our programs have no insurance, or no insurance to cover outpatient services (up to 60% in some programs), and as we have no means to pay or provide for medical services, our clients do not receive the quality care which is available. Many cannot pay for lab work that is often routine. Many cannot follow-through with recommendations that they see another specialist to rule out possible complicatioins or even causal conditions (i.e., neurologists, endocrinologists, internists, etc.) They cannot receive treatment for acute illness, or other chronic conditions besides their mental illness. We have watched as many clients have ignored physical illnesses due to lack of resources to purchase care.

The impact of all this is at times devastating. We know we could do better if the client had access to health care. When we think a physical problem is contributing to a mental dysfunction, and cannot get that verified, we can do nothing but assume it's mental illness. Somatic complaints can become a major issue in treatment if they are never checked. Monitoring blood levels is a crucial piece of treatment, and often we are unable to do this. The medications our clients use are extremely powerful, and can cause many different problems. Of particular concern are the neurologic risks, the endocrine system, the immune system, as well as the digestive system. All of these systems can suffer irreversible damage from the medications we prescribe. Yet, we cannot monitor these even in blood work, because the client has no ability to pay.

At the same time, we are unable to treat potential clients who would most effectively be treated by us, simply because they do have the ability to, at a minimum, pay a private practitioner to continue their meds. This practitioner, in all likelihood, has none of the other resources we have, to help that client/patient function at his/her optimal level in the community. These clients, then, are also not receiving the best possible service available.

As long as there is more demand than supply, our decision regarding admission for service should be of a clinical nature, not an economic one. We have ended up serving too many of the "wrong" clients for the "wrong" reasons. Our largest demand for service is for our "Medication Only" Program. This is an outpatient style program. The client sees the doctor for medication reviews, and the nurse/casemanager for other support services. This program, while lending itself beautifully for reimbursement, suffers the most financial drain on behalf of the uninsured client, often times not as needy of our expertise with this population as the client seeing a private physician every three months. It ends up not fair to anyone.

What kinds of things could we do? Make Medicaid more available to more people. Reduce the red tape and requirements, and increase its pay structure and timliness to make it more attractive to more service providers. We should monitor care in public settings simply because we are concerned about the quality of that care rather than to simply fit Medicaid regulations.

We could expand the Public Health Department to include routine health screening services as well as their current roles in communicable disease.

We also need to expand efforts at cost containment in Health Care. Even people who have insurance coverage can find medical treatment too expensive to persue. The concept of Human Services needs to continue to grow, define itself, and make its voice heard among policy makers and budget writers. Somehow, human needs must be seen as being of at least equal importance as defense, environment, the state itself, and the symbols our country thrives on.

Thank you very much for this opportunity.

Sincerely,

Debra K. Overton, ACSW
Program Supervisor
Partial Day Services

DKO/cg

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~~43525 ELIZABETH~~
MOUNT CLEMENS, MICHIGAN 48043

(313) 469-5235

DANIEL C. LAFFERTY
Director/Health Officer

LELAND C. BROWN, M.D.
Medical Director

July 7, 1989

TO: SENATOR DONALD W. RIEGLE AND MEMBERS OF THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

During the month of May, 1989, recorded general phone calls numbered 314. Of these calls, 30 were identified as referral requests for low income medical care. An example of these calls is as follows:

On June 27, 1989 a 33 year old gentleman called. He is employed but has no medical benefits. He needs medical follow-up to rule out Lyme Disease. He has no money for doctor, lab work, or medication. There was nowhere to refer him to.

Sue Sheridan, R.N. B.S.N.
Sue Sheridan, R.N., B.S.N.

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July 20, 1989

Dear Senator Donald Riegle

We recieved your letter about getting health care. The letter was about a meeting in Southfield on June 28. Well, your letter was dated June 8, but we didn't recieve your letter June 29. It wouldn't surprise me if no-one showed up at the meeting in Southfield.

And yes all three of us need health care. My daughter Nancy was born with birth defects. She is 18 now, but she has been denied health care. I am going on 50 years old, & haven't seen a doctor in years because I don't have enough money to pay for it. Ive got a problem that needs attention, & I can't get a job because of it. My Son Robert hasn't been sick in a long time, but if it ever happens that he gets sick, I don't what he'll do. HE's been working at the same job for 11 years, & the employer just isn't interested in getting health care for the employees, because its so expensive.

Sincerely
Valerie Manney
Nancy Manney &
Robert VySE
9 Maynard Ct.
Pontiac, Mich
48058

Dear Sen Riegle, June 26, 1989

I wish I could be there at the hearing June 28 re: health care for the underserved.

I am in favor of National Health Insurance for many reasons.

At this very moment - I am desperately seeking surgery for an emergency situation, and so far have not been able to obtain Medicaid. This surgery should have been done several years ago and the fibroid tumors have multiplied and expanded.

Last year May 18 at midnight I went to the Emergency room at Bi County without insurance - hemoraging from fibroids. They kept me in emergency (without admitting me)

2

as I continued to hemorage all night. My blood count which should have been the normal 15 - dropped to 7 and approx 8:00 A.M. emergency surgery was performed. Before surgery the attending surgeon told me in the operating room "I may not be able to stop the bleeding". I found out later that the body at first hemoraging - resists and produces clots. As the hemoraging goes on / continues - the body loses the ability to clot and then the hemoraging is a steady flow - which cannot be stopped. (I should have explained these are uterine fibroids and polyps)

Anyway the hospital kept me in emergency + waiting status and never did admit me. — (also am a diabetic)

My point is - chances were taken with my life - due to the fact that I have no insurance.

My husband has been disabled since 1970. Our income is net Soc. Sec. #459 per mo. I sell real estate but have been unable to work seriously at it because of this hemoraging for 5 yrs already. We can't come near to paying for Blue Cross for me. In fact I have applied to Blue Cross several times and believe that the reason I do not get a response from them to my applications - is do to my previous (close to 10) hospital admissions beginning in 1965. By the way those 10 admissions from 1965, under Blue Cross - were all at Bi County.

In other words - when I did have Blue Cross, I did my business at Bi County. I've been going there for 24 yrs.

My whole point is - I am not finding fault with Bi County. But I do think we need a National Health Insurance that covers everyone. Equality should apply to protection of one's health and life as much as all the other areas of our society.

Respectfully yours,

Mrs. Keith Mason
13646 Ryan Rd.
Detroit, Mich. 48212
1-313-893-1466

P.S. I am a registered voter + thank you for your effort here.

Health Care for the uninsured... is it a right or a privilege? In the past two years I have come to appreciate the meaning of Health Care and how important it is to each of us and I feel my involvement in the Michigan Coalition for Access to Health Care and my job at a physical rehabilitation and fitness center established for the purpose of enriching lives through physical fitness have given me a new insight into the needs of individuals who are struggling with disabling conditions and the health care system.

I have been "mainstreamed" throughout my life and have tried diligently to advocate for others whenever I have experienced similar problems. The health care issue is a long and ongoing concern for persons like myself because there have been so many obstacles in the health care field. I feel we need more awareness in the public sector to educate people about the uninsured's needs. A catastrophic illness is beyond a person's control, however, a "healthy" person sometimes takes "health" for granted. Unless a person actually experiences difficulties in the "system" they don't really know or have a full awareness of dealing with an illness or added problems as a result!!

I am hopeful that the young children now being brought into the "system" as a result of a disabling condition, and who are able to be "mainstreamed" into as normal a life as can be expected for them that they will live a more stress-free, easier because of experiences having gone through by people like me. Starting early will make a much brighter future for children.

I also wish to express my concern over the government involvement at trying to bring the issues out in the open. I wish to go on record as saying "I appreciate your help, but as a person *first* and a handicapper *second* let's remember that a handicapped person doesnot wish to be treated *differently*! They deserve to be treated as a person 1st!!" Let's not pay a new government person at this time (in the private sector) to do something when we have smaller entities (insurance companies) trained and competent to step in with minimal guidelines for extenuating circumstances only. More persons nationally would be able to be involved and there would be a renewed sense of helping each other – instead of .. it's not my problem or "oh no, here comes one of those handicappers again"!

It has been my experience in my adult years more specifically, to come to a keener understanding of what it means to be handicapped in the U.S. Some of it is national and some probably is not. I do feel good about the movement taking place for persons who have been in the "system" before and have grown stronger and independent as a result of temporary help - such as myself. I am thankful for the security I had during that time in my life. However, there are not many incentives for enriching the quality of one's life when they depend solely on our government or Social Security. I understand the reasoning behind using this means for financial resources for needy individuals. The public's perception of persons needing this service is totally distorted! I do not believe that Social Security is a sound alternative for T.A.B. (temporarily able-bodied) people to use as their source of income if they become disabled or handicapped.

Thank you for asking me to participate in this hearing and present this to you. I feel we are moving on to better communication and a better quality of life for those who need it and deserve it! I have enclosed some literature about a program that has turned this handicapper's life around and I wanted to share with you one man's idea and how it has affected lives.

If one person is innovative to the point of turning others' lives around, why can't we as people do that for each other with the help of the government, the private businesses and each other?

We just want to be accepted as people with a handicap for what we can contribute to society - not take away!

Good Luck in your pursuit of access to health care for us all. You have my support! Feel free to call on me anytime to say what is in heart!

Many Good Wishes to you,
Sincerely +
Healthfully,

Pam Yankowski
7129 Hilltop Ave.
Traverse City, MI
49684
Ph: (616) 947-5101
941-8111

The Detroit News
Monday, October 21, 1985

‘Miracles’ of recovery

PHOTOS BY JOHN L. RUSSELL

Above: Tim Bloomquist assists Amy Rogers on the lap pull-down exercise. **Right:** Larry Zoulek works on the hip-abduction machine with Jeff Haas of the Fitness for Life Enrichment Center in Traverse City.

itness for Life Center uts the handicapped n the comeback trail

You don't always have to have the lead if you have he heart to come from behind."

y Leslie A. Schneider
ews Special Writer

Pam Mankowski wasn't like other children. It took her three years to learn to ride a bicycle and a year to master the Hula-Hoop. For 36 years she has had cerebral palsy, a physical impairment that prevents her from controlling some of her movements from the hip down. The developmental disability, with her since birth, has affected every aspect of her life.

The winter of 1984 was a tough one for Ms. Mankowski at her home in Traverse City. The Social Security Administration declared her completely disabled in 1976, and she was confined to her home. She often had muscle spasms so painful she had to be hospitalized.

Facing the winter of 1985, "I knew it was coming and I was petrified," Ms. Mankowski recalled. When she questioned a Traverse City doctor about her condition, he told her to "take the pain pills and Valium and live with it."

At the age of 45, Larry Zoulek, also of Traverse City, was no stranger to pain. A near-fatal automobile accident five years ago resulted in arthritis and fibrosis, a condition that doctors at the University of Michigan Pain Clinic describe as chronic pain. Before the accident, Zoulek had spent most of his life working two jobs. After, he was also declared disabled.

"All of a sudden it was all taken away from me. I got bitter," he said, adding that he turned to Valium

Please see **Handicap/3D**

Handicap Center offers 'miracles' of recovery

From page 1D

and Percodan, always carrying at least 100 pills with him. Three years ago he ended up at the Traverse City Regional Psychiatric Hospital after a nervous breakdown.

"I kept myself in a stupor and wound up in the state hospital for three weeks because of the drugs."

Zoulek faced the winter of 1985 on the verge of another nervous breakdown and contemplating suicide. "It had gotten to the point where every time I left the house, my family didn't know if I'd come back," he said.

But Ms. Mankowski survived the winter of 1985, the most severe in the past decade, without being hospitalized. And Zoulek did not attempt suicide or have a nervous breakdown. Instead, both began strenuous workouts three times a week at a local fitness center. It literally changed their lives.

THE FITNESS for Life Enrichment Center (FLECs) last September began offering individual, intense physical fitness programs to 47 mentally and physically impaired people. The idea for FLECs began five years ago when Jeffrey Haas, then a mental health professional, began questioning the assumption that a person's psychological disability was directly related to his or her physical capacity. While the mental health system attempted to deal with fitness needs of clients it was frustrating for Haas.

"People were not showing any progress," said Haas, a fitness buff who has done graduate study in exercise physiology. "Society accepts and encourages developmentally disabled people to be dependent on society, and they believe this is their responsibility.

"SO I PICKED a couple of people initially who, I felt, had coordination problems and were fairly profoundly retarded," he said. "Louise" was the first client to go with Haas to The Body Shop, a Traverse City fitness center. A 42-year-old woman diagnosed as having Organic Brain Syndrome with a measurable IQ of 30, she had spent the majority of her life in institutions and adult foster-care homes. Louise could not walk up or down stairs or get in or out of a car. When Haas and another person lifted Louise onto the stationary bicycle, she couldn't turn the pedals.

A pre-FLECs report stated Louise's prognosis for success in the program as poor. But 15 months later, Louise was running up and down stairs, getting in and out of cars, and had to be reminded she could only ride the bike for 30 minutes. She later went to work in maintenance at an apartment complex.

"People always assumed she couldn't do anything. We always assumed she could," Haas said.

In February 1981, Haas and other mental health professionals began taking about 25 of their clients to The Body Shop three times a week. Then in June 1984, Haas decided to venture out on his own, after he received a small grant from a Detroit bank. That December, FLECs was chosen for a demonstration grant from the Michigan Developmental Disabilities Council.

FLECS SHIFTED into full-swing, with computerized fitness evaluations that measure cardiovascular efficiency, muscular-skeletal imbalance, posture and gait, motor skills and body composition. The computer evaluation was recently copyrighted. With the results of the six pages of printout, physical therapist Lise Zahn and Haas wrote an exercise prescription on each client's differing needs.

The individualized prescriptions contain instructions for special considerations, a warm-up, weight training, an aerobic exercise and a cool-down. Also in the prescription are goals for the next three months. FLECs clients begin working out in small groups with the aid of Haas and Tim Bloomquist, a FLECs staff member. After an evaluation update every three months, a new exercise prescription is written, with emphasis on accomplishing new goals.

"IF YOU DO an exercise wrong, you can do a lot more harm than good," said Bloomquist, a former mental health counselor with a degree in physical education. "We ask them to work as hard as they can, as well as they can, and to have fun. If getting into shape isn't fun, they won't keep at it."

Many of the FLECs mentally impaired clients need constant supervi-

Please see **Handicap/4D**

Fitness for Life Center offers 'miracles' of recovery

4D/THE DETROIT NEWS, Monday, Oct. 21, 1985

Handicap

From page 3D

sion and instruction. Without Haas or Bloomquist, The Body Shop would become a maze of incomprehensible steel and mirrors. And without the knowledge behind Haas, Bloomquist and Ms. Zahn, The Body Shop would become dangerous for many of their clients.

"They (clients) enjoy being physically active because it doesn't hurt anymore," Ms. Zahn said. Clients' physicians are also contacted when special physical limitations are present.

OFTEN, people who are mentally impaired will have physical problems that they don't speak up about, Ms. Zahn said. "FLEC's gives them a voice." When Ms. Zahn sees a particular physical problem in a client, she is sometimes the first to have ever pointed that out. A client's exercise prescription then takes that problem into consideration.

One man had a relatively low heart rate when doing his aerobic exercise during a evaluation while at the same time, his blood pressure soared. Haas now monitors the man's blood pressure rate during his aerobic workouts.

Another man with Down's syndrome weighed 230 pounds at 5 foot 2 inches tall, and had a severe problem with balance. As a result of the fitness evaluation, Ms. Zahn had him lifting weights free-style, in front of a mirror. His balance improved tremendously over the next few months. He also lost 70 pounds the first year with FLECs.

DURING HER hospital stay last year, Pam Mankowski became good friends with Karen Culp, an R.N. in the Rehabilitation Unit of the hospital. When they first met, Ms. Mankowski was wheelchair bound. Before she was released from the hospital, she was "walking like a little old lady, bent over a walker," Mrs. Culp said. Although Ms. Mankowski always smiled, Mrs. Culp knew Ms. Mankowski was worried she was a burden on her family.

Together they searched for a physical fitness center that would help but not injure Ms. Mankowski. After hearing about FLECs, Mrs. Culp told Ms. Mankowski, "This is it!"

With the goal of making it through the winter without having to be hospitalized, Ms. Mankowski began working out three times a week with FLECs. "To tell you the truth, I was scared to death. I'd never worked on machines. Anytime I'd had physical therapy it brought back bad memories. It always hurt me," she recalled. When Haas began setting other fitness goals for her, she said to herself, "I don't know . . . I think he's biting off more than he can chew."

"THERE WERE some adjustments she had to make in her life because it was very hard for her," Mrs. Culp said. Before FLECs, Ms. Mankowski could not lie flat on her back, and could not do any conventional exercises. "We needed a completely unique approach for Pam. We had to devise exercises that she could actually do," Haas said.

One day early in the program, Haas noticed that Ms. Mankowski had tears in her eyes as she was doing single leg raises: "I remember saying to her, 'Pam, it looks like you're hurting. Let me know if it's unbearable.' She forced a smile and told me, 'This is no more pain than I have to deal with every day of my life. Let's get on with it.' "

"I guess when you have faith in it, you put your soul into it. I guess that's what I did," she said.

THE FIRST fitness evaluation Ms. Zahn completed with Ms. Mankowski last September showed her in "poor" physical fitness, the lowest fitness rating. Ms. Mankowski couldn't even complete part of the test. She could not reach below her waist, or do any sit-ups. Three months later, she moved up to the "fair" fitness category; increased her work output by 28 percent; increased her oxygen metabolism 25 percent, could reach within six inches of the ground; and could do six sit-ups.

"I couldn't last five minutes on the bike the first week," said Ms. Mankowski, adding she now bikes 30 to 45 minutes three times a week. Her posture has also greatly improved.

"When I think of the Pam I saw last year, smiling on the outside and crying on the inside . . . wanting more control of her body and her life . . ." Mrs. Culp said. "She's moved through the winter. She's become brighter and brighter, taller and taller and has more self-confidence. It's really working."

IN FEBRUARY, Ms. Mankowski began working as an office manager. The agonizing muscle spasms that often caused hospitalization have subsided. She still has tough days but, "I don't have the same type of tough days I used to," she said.

Ms. Mankowski recently told Haas she played on the floor with her second child, now 3 years old. When Haas didn't react, she told him, "Jeff! I've never been able to do that before!"

"It's been a big release of my emotions. I can make it through a winter. I'm going now. I'm not going to stop," she said.

Larry Zoulek echoes Ms. Mankowski's sentiment. "I'm on my way. I've got some goals. I'm going to be a permanent fixture in this place. I'm hoping by 1986 I can be self-supporting again," he said.

"WHEN I WENT in there in December I could hardly walk," said Zoulek, adding that he had a limp and often fell down stairs. "You can't even sleep nights, you hurt in too many places."

After he talked with Haas and set up a fitness evaluation with Ms. Zahn, "I thought, sure, I've heard this before." In the previous five years, Zoulek had joined different health clubs in the area and calls those experiences "flops." "God, now they can't keep me out of the place."

Zoulek was also able to quit his two-pack-a-day cigaret habit, and feels more self-confidence than he's ever felt before.

He still has some pain, but while he's exercising, his body produces natural pain-killers, believed to be endorphins. Although not much is known about these neuro-chemical releases in the body, Lise Zahn said this is possible.

"With enough of the right kind of exercise — not highly stressed — people can experience a pleasant fatigue sensation which can help reduce pain or discomfort," she said.

WHEN HE STARTED with FLECs, Zoulek needed Haas to talk him through the entire program. Now, Haas only needs to take Zoulek's heart rate, "and he pats me on the back and tells me what a hell of a nice guy I am."

One of Haas' goals is to make clients more independent, not only in the real world, but within the program. FLECs clients start out having one-on-one supervision from Haas or Bloomquist. Many times, clients need to be manually assisted to complete an exercise.

When 29-year-old Amy Rogers began working out with FLECs last December, she couldn't do many of the weight-resistance exercises on her own. "I had to manually assist her to make the movement on the leg-curl machine without any resistance at all," said Bloomquist of Ms. Rogers, who is mentally retarded. After she was able to curl her legs back on her own, he put his hands on the back of her ankles for some slight resistance.

After that, she was able to lift the roll on the machine, but again, with Bloomquist's assistance. A week later, she was able to use the machine on her own but without full range of motion. "Finally, she did it unassisted with the lowest weight or resistance," he said. Ms. Rogers now lifts 15 pounds on the machine.

"IT'S REALLY difficult for someone like Amy with her limitations to pursue physical activities. It's not something she can go out and seek by herself. She needs a structured type of activity," said Chris Ibbotson, program director for the community living center where Ms. Rogers lives.

Three days a week when Ms. Rogers is scheduled to go to FLECs in the afternoon, "at 8 in the morning when I come in, she announces she's ready to go," said Ibbotson. "I think she'd go five days a week if that was available.

"She's becoming stronger, she's developed more stamina, and she can't help but feel better, be more flexible and have more endurance," Ibbotson said. About the same time Ms. Rogers started FLECs, she began working on a maintenance crew through a sheltered workshop. At first, supervisor De Cook, wasn't sure Ms. Rogers could handle the work.

"I really suspected there would be quite a few things she couldn't do," he said. "She's turned out to be a great surprise." Since FLECs, "she started picking up. She's had a 20 percent increase in production," and FLECs is responsible for at least half of that, Cook said.

Eventually, Bloomquist hopes Ms. Rogers will be able to exercise with her workout partner without his individual attention. She may someday be able to exercise completely on her own, and she hopes to be able to live alone in an apartment.

INDEPENDENCE is the goal of the FLECs program. It's stressed for the clients within their individual fitness plans, so that Haas and Bloomquist can begin working with other clients. It's often a result of three or four months of hard work with FLECs, after which clients find themselves more independent within the community. It's also a goal of the FLECs program as a private, nonprofit corporation.

"People look at non-profits and think of churches and mental health systems. We like to think of ourselves as a business-oriented human service," Haas said. "When they enter our program, about 90 percent of our clients are on fixed incomes and not able to afford our services, so our ultimate challenge is to be able to subsidize the cost for people on low incomes via our own business ventures," Haas said, adding that he hopes to market their services to the community and have membership dues underwrite the costs for the handicapped.

LOCALLY, FLECs has a waiting list of 84 people with developmental disabilities, mental impairments, substance abuse problems, closed-head injuries and arthritic conditions. In Michigan, more than 20 different groups wanting to begin a center have approached Haas, he said.

Haas recently trained the staff of the Macomb County Life Consultation Center in Mt. Clemens to set up and run a Fitness for Life Enrichment Center. He also hopes to set up FLEC's nonprofit "franchises" throughout the country.

"FLEC's is unique because of its scientific, comprehensive approach to wellness. And I think it's marketable to the general public because it gives success-oriented structure and support to everyone trying to get into good physical fitness."

Martens and
Associates

June 26, 1989

Donald W. Riegle, Jr.
United States Senate
Washington, DC 20510

Re: Uninsured health care hearing

Dear Don,

May I commend you for the public hearing on health care for the uninsured to be held on June 28, 1989, in Southfield, Michigan.

Please add this letter of testimony to the transcript of the hearing. It is of the utmost importance that all Americans, no matter what their financial means, be able to provide themselves and their families with adequate medical care.

As president of a company that deals with Employee Assistance Programs, it should be mentioned that we are acutely aware of the need for some form of health care for every citizen. Even though our experience is primarily with the private sector of the economy, we do see a vast need for the help you are proposing.

Please don't give up on this major issue. All of us as Americans should have the privilege to try to provide for ourselves.

I have enclosed a copy of our "Company Background" to help give you a better understanding of what we are engaged in at Martens & Associates. If there is any way that myself or a member of my staff could assist you in this matter, by all means please let us know.

Sincerely,

John E. Martens

John E. Martens
President

enclosure

COMPANY BACKGROUND

When we say "Productivity Consultants" on our letterhead - WE MEAN IT ! Martens and Associates is a unique Michigan based company dealing strictly with alcohol/drug abuse education and programs for business, municipalities and government agencies. In fact we are one of the few organizations in the entire country devoting itself to this one field.

Don't be mislead by this title. Productivity is indeed a major concern of anyone in a leadership role, no matter where that role is applied. Employee Assistance Programs (EAP's) are NOT just another expense or nuisance forced upon management by unions or civic groups. If you are finding it difficult to make the connection or the connection is somewhat unclear, try answering the following questions:

> Are your current personnel, whether hourly or salary, working to their full potential, unhindered by chemical dependencies?
>
> Is everyone in the office or shop working in harmony, as a team?
>
> Are there disgruntled employees because a few are taking obvious advantage of alcohol or drugs during working hours - and getting away with it?
>
> Is there excessive absenteeism by some who are suspected of drug or alcohol abuse?
>
> Do your employees know where to find help for a family member with a dependency, alleviating their own burden?
>
> Does your current program boast of a 25% success rate?
>
> Do you have some form of assistance for the employee who genuinely wants to or needs to change their life?

Today, the associations in the forefront have the correct answer to every one of these questions. They are successful in whatever their venture. Their employees do give them 100% and even enjoy the idea of coming to work. And, it is not uncommon to find them listed in publications throughout the world as leaders in their fields.

Do you find yourself searching for ways to improve performance, increase attendance and boost moral? Do you want to be in the forefront - with the leaders? Is there something that tells you; "I probably should do something, but what?" Become a LEADER ! Talk with us. We've helped others. Why not YOU ??

My husband passed away 1yr ago.
I have one son going to Eastern I pay
$540 quartly for our H a p medical.
You wonder why so few people vote
This country is only for the rich so
let the rich fight for theyre money
let their sons go & serve for all I
know even with a college education
my son may end up working for
Mac Donalds the way the Japanese &
Arabs are taking over. The presidents
want our kids to work for $5.00 hr.
This is our leadership & This is
what our country has come to.
This is what theyre uncles & father fought for

Thank You Kindly

Mrs. L. Matusik
8052 Cartland
Allen Park, Mich
48101

Dear Mr. Riegle

I received your letter about health care. I am writing this letter because I feel we the little people have no representation & haven't for a long time.

My husband was born in this country his brother fought under Patton my husband was on Guam his brother in Korea & our son in Vietnam.

He worked for ex Cello for 28 yrs they folded up he landed without a pension after all those yrs of faithful service He got sick with leukemia & T.B we had to get a attorney to get disability he fought his illness for 5 yrs it cost us $2,000 to finally get it.

People come here from foreign countrys get food stamps & welfare we raised 4 kids sent them to Catholic school scrimped & saved never went anywhere

MCHS Infant Mortality Project

53 Candler Avenue
Highland Park, MI 48203
(313) 868-8420

June 27, 1989

Senator Donald W. Riegle, Jr.
Wayne-Monroe
1850 McNamara Federal Building
477 Michigan Ave.
Detroit, MI. 48226

Dear Senator Riegle Jr.,

Thank you for giving us an opportunity to respond to your invitation to submit written testimony related to the problem of access to health care for uninsured individuals.

We represent the Michigan Catholic Health Systems (MCHS) Infant Mortality Project. This is a private non-profit agency which has developed the Parent-Infant Partner and Literacy Programs to assist in reversing the high infant mortality rate in Detroit and Wayne County.

In the past two years, we have served a number of clients who have had a significant problem in obtaining health care especially early prenatal care because of their lack of insurance. This delay in health care during pregnancy continues to be a contributing factor to the high infant mortality rate in Detroit and Wayne County. Our daily work with uninsured clients gives evidence of the great need for some form of a universal health care.

We commend and support you in your efforts to establish high quality, affordable health care, not only in Michigan, but to all Americans and their families. If we can be of further assistance to you in your work please contact us at #868-8420.

Sincerely,

Sharon C. Wallace
Sharon C. Wallace, BSN, CNM
Support Program Director

Paris M.
Paris M. Wilson, BSN
Support Program Coordinator

Beverly Ciokajlo
Beverly Ciokajlo, M.A. Ed Spec.
Literacy Program Coordinator

McPherson
Hospital

Livingston County's Full Service Hospital

Peter J. Schonfeld
*President &
Chief Executive Officer*

June 12, 1989

Senator Donald W. Riegle, Jr.
Central Office
705 Washington Square Bldg.
109 W. Michigan Ave.
Lansing, MI 48933

RE: HEARING BY SENATE FINANCE SUBCOMMITTEE ON HEALTH

Dear Senator Riegle:

This letter is in response to your request for written testimony to be included in the public record as part of the hearing by the Senate Finance Subcommittee on Health, scheduled for June 28, 1989 in Southfield, Michigan.

The problem of healthcare for the uninsured is getting worse. Non-reimbursed care for those who can't or won't pay is costing Michigan hospitals nearly one million dollars a day according to the Michigan Hospital Association. We believe that no one should be denied access to essential healthcare for financial reasons, but we also know that to continue this practice at current levels will bankrupt many hospitals. Charity should be used to patch cracks in the system, not to fill entire holes.

In the past, the government payment systems for healthcare and private health insurance permitted hospitals to pass on the cost of providing charitable care. However, public policy has now changed and these costs cannot be passed on to the government nor to private employers through higher charges to insured patients.

This past year, I have enjoyed the privilege of chairing the Michigan Hospital Association Task Force on The Vision of Healthcare in the Year 2000. Our vision is for a system of universal sponsorship where every citizen belongs to a private or public program covering a substantial portion of basic healthcare costs. We do not propose that everyone has the same benefits, rather, that everyone has at least some basic coverage. This does not mean that there is a single financing mechanism for this program, but only that the results add up to universal coverage.

We need to create an incentive system that encourages and rewards efficiency and pays fair and adequate compensation to providers of healthcare for delivering those services.

Currently, one-third of Michigan's hospitals have chronic financial operating losses. Within our association, we are facing the agonizing challenge of how we can change and still maintain local influence over healthcare delivery. At the same time that we prepare for these inevitable changes, we ask that there be political leadership to ensure equitable financing and even distribution of healthcare delivery.

Sincerely yours,

Peter J. Schonfeld
President & CEO

PJS/pk
cc: S. Johnson - MHA
    D. Potter - SEMHC

3737 Kent Street
Flint, MI 48503
June 24, 1989

Senator Donald W. Riegle, Jr.
182 Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Senator Riegle:

Thank you for your notification of June 5, 1989 about the Senate Finance Subcommittee hearing you will hold on Wednesday, June 28 at Southfield on a federal health care system. I appreciate the opportunity to provide written testimony and the invitation to attend the hearing.

My thoughts regarding a federal health care system are still as I outlined them in my letters of July 12, 1987 to you and Congressman Kildee. Rather than parrot them in this letter, I am enclosing a copy of that letter. I do have these additional thoughts.

1. With a proper federal health care system, most of the facets of our present efforts--medicare, medicaid, catastrophic health care, employer financed health care, health care and HMO policies by insurance companies would become history.
   a. The care intended in medicare, medicaid and catastrophic health care would all be provided for in a unified proper federal health care system.
   b. Employer financed health care insurance is most admirable, but inadequate.
      1) The unemployed and many, many whose employers do not furnish health insurance have no health care protection.
      2) Medicaid recipients are often spurned and very hard pressed to find doctors and medical facilities willing to serve them.
   c. The health care plans and HMO's sold by insurance companies are incongruous with true health care for all Americans.
      1) Typically, insurance companies will not sell a health care policy to an applicant who comes to them with a health problem or problems.
         a) If the insurance companies will sell a policy to a person with health problems, the policy will not cover the particular problem or problems; or they will charge a much higher rate if they do cover the problems.
         b) Typically, at the first opportunity, the person is cancelled.
      2) This is no criticism of the insurance companies--set up to earn a profit, they have no other choice.
2. With a proper federal health care system, every American would be provided with all the health care he or she may need from birth (even before, when necessary) to death.
   a. Every American means the unemployed as well as the employed.
   b. Every American means those with health problems--whatever they may be--as well as those in good health.
   c. All the health care means all the health care and includes: dental, vision, hearing and mental, as well as physical care.
3. How would such a proper federal health care system be financed?
   a. Every American unit (family or individual) would pay a premium.
   b. The premium would be based principally on 2 factors: 1) income group and 2) age group.
   c. The premium would also be based to a much lesser extent (say 5%) on good health habits as avoiding tobacco, alcohol and other harmful products, but engaging in healthful activities as regular exercise, proper eating and weight control.
4. The income factor, like income taxes, would be based on the principle of ability to pay--with reasonable, realistic minimums and maximums.

   a. The minimum rate would impress upon those with very low incomes that they too, have a part in paying for the service.
   b. The maximum rate should not penalize those with high incomes for their achievements.

5. The age factor would reflect the greater risk of health problems as one moves into successive age groups.
   a. Like term insurance, rates would increase at a steadily increasing rate from 1 age group to the next.
   b. The maximum rate would be for the 65 and over group.
      1) The rate should be high enough that the 65 and over group would be paying the full cost of their ever increasing medical care.
      2) Younger groups should not have to subsidize any part of the expense of care for the 65 and over group.
         --Because of the exorbitant cost of housing, younger groups, even with husband and wife both working, are very hard pressed to maintain a decent standard of living.

6. Two further points need to be addressed.
   a. Money now paid by employers for health care insurance should go to the employees direct so that the employees may pay for their own health care premiums.
   b. Doctors and medical facilities who deem their services worth more than the system designates, should be free to restrict their services exclusively to those with the money to pay for such superior service. They should be barred from participation in the federal health care system.

Sincerely yours,

Marion I. Meeker

Marion I. Meeker (Mr.)

Enc.

When I became eligible for Medicare in January of 1986 and read of the benefits and became aware of the deductibles, I was very, very disappointed. I concluded that Medicare is positively preposterous and resolved to do what I could to get it straightened out.

Despite the best of intentions, tending to daily chores and other matters as they arose has taken up my time. Now, however, Senator Riegle's "Report to Michigan Senior Citizens," does prompt me to get started. I will give my comments in outline form for easier reference.

1. I am glad the Congress is working to solve our health care problems.
2. My concern though, is not only for senior citizens, but all age groups—especially in a time when large corporations are forced to terminate the employment of so many workers—white collar as well as blue collar.
   a. By the way, the term lay-off, as used by the press, is a real misnomer.
      1). To my way of thinking, lay-offs are temporary.
      2). These terminations of employment are permanent—just ask those families whose walls are tumbling down around them.
   b. These terminations of employment are leaving a rapidly increasing number of families without health care insurance, and consequently, in many cases, without proper health care.
   c. So many people are forced to take jobs that are not only much lower paying, but also without any Health Care protection.
3. DELETE THE DEDUCTS. No individual or family with a need for health care should have to pay anything at all for that care—for as long as they need it; all services should be covered.

a. This means no limitations on the length of time the care is provided.

b. This means all health care from treating a cut to caring for the worst lingering catastrophic illness.

c. This means no individual or family should have to lose any of their life long accumulations (money or property) at all to a nursing home, hospital, the government, a social organization, or any other body.

--the misery and suffering of a family or individual struck with the misfortune of an accident or illness is more than enough to bear--without being rendered destitute as well.

4. Decent and respectable Health Care for all should be not charity, but a right--regardless of economic position or lack thereof.
   --Those who have the money for care beyond the standard should be able to purchase that additional care.

5. Every individual should be entitled to decent food, clothing and shelter, as well as Health Care--again not as charity, but as a right.
   a. So far as I know, nobody asked to be born into this world with all the hardship and misfortune that befall so many.
   b. This is especially true of the individuals and families who are victims of unemployment, illness and divorce.
   c. This item #5 departs from the topic of health care, but needs to be addressed in connection with health care.

6. Who pays for all of these benefits? The government, of course!
   a. Seriously, such a program should be paid for through insurance premiums by all citizens of this country--according to their ability to pay, up to a practical maximum.
   b. I am glad to see in Senator Riegle's report that most proposals would use this method to finance Health Care.
   c. The program must pay all the bills--no deductions.

7. I hope we can avoid the shortcomings of Health Care programs in other countries.
   a. We need to be ever alert for abuses by some members of the public and some members and facilities of the medical community.
   b. We need to be sure that the lengths of stays for patients are adequate and safe.
   c. We need to be sure that doctors' fees and payments to hospitals and other care providers are not exorbitant, yet fair and sufficient.

8. Do we need to re-examine our philosophies of Health Care?
   a. Why, under our present system of a number of independent insurers, can we not allow the dependents of a deceased member of a Health Insurance program to carry on with the same group coverage, instead of forcing them to a more expensive individual policy with fewer benefits and likely, no Health Care at all?
   b. Would the mentally handicapped persons be better cared for in institutions appropriate to their particular condition, instead of being turned out into the streets or relegated to so-called halfway houses where so often, the care is totally inadequate?
   c. Are we really doing the "elderly" a favor by our continuing emphasis on increasing their longevity--considering the burden they often come to be to their loved ones and to themselves?
   d. In the event of being struck with a catastrophic illness, while still of sound mind, might the individual better decide whether or not a life support system should be attached?
   e. For the greater good of the individual and the nation, at which season of life's journey should the greater portion of available Health Care funds be invested? The Springtime? Or the Winter?

Sincerely yours,

Marion I. Meeker (Mr.)

TESTIMONY, U.S. SENATE FINANCE SUBCOMMITTEE ON HEALTH

WEDNESDAY, JUNE 28, 1989

I am submitting this testimony on behalf of the Mental Health Association in Michigan. We are a non-profit, non-governmental organization promoting mental health and improved treatment of persons with mental illnesses and developmental disabilities.

The sub-committee's interest in the problem of access to health care for the uninsured is a laudable one. Every day, every year, more than 40,000 Americans seek health care and are turned away, or neglect their health because they cannot afford the care they need. 37 million Americans have no insurance coverage and another sixty million have inadequate coverage. Health care for these millions - many of them children - must be made accessible.

This will involve many difficult policy decisions over who to cover, how to pay for the and what to include in the coverage. We in the Mental Health Association in Michigan believe that - whatever else is done - no health care system can be considered complete nor fiscally responsible unless it includes coverage for mental health services. We urge your consideration of this viewpoint.

Beginning with the discovery and use of psychopharmeceuticals in late 1950's up to today researchers continue to discover more connections between physical and mental health. They are not only discovering many genetic and chemical causes of disorders but also are verifying what many practitioners have believed for years; that the links between physical and mental health are many and are strong links.

We cannot, as a society, afford to neglect this important aspect of health care. A wealth of studies now show the link between physical and mental health, as well as the cost implications of failing to address the mental health needs of the population. For instance:

-people with good mental health tend to live longer and have fewer diseases than people with poor mental health;

-different personality factors cause certain kinds of cardiac disease;

-in grief, people's immune mechanisms alter so that they cannot defend themselves as well against infectious diseases.

Many physical ailments have been linked to emotional problems, and practitioners are beginning to understand that emotional and physical health are highly interrelated. When a mental health service is incorporated into the delivery of general health services, there is substantial cost-offset resulting from reduced utilization of medical/surgical services.

When American business addresses the need for adequate mental health services for employees, studies indicate substantial cost savings are achieved. Based on data compiled by large companies, the Washington Business Group on Health concluded that the benefits of psychiatric coverage were: improved employee productivity; reduced absenteeism; improved employee morale; reduced hospital/surgical/medical utilization; and lower insurance premiums.

These realizations are beginning to bring about changes in attitude toward mental illnesses; with clients and their families asserting their right to treatment rather than perpetuating the assumptions that mental disorders are self-induced or caused only by family and life situations.

There are a number of factors which, in the past, have mitigated against the inclusion of mental health coverage in insurance and benefit plans. When the cost of health care escalated so dramatically, employers and unions began looking for ways to reduce costs and coverage for mental health services was often the first to go.

Despite statistics showing that 1 in 5 persons will sometime in life experience the need for mental health services, most of us don't believe we will be in that 20%. We know we'll develop dental cavities or other problems with our teeth, but are convinced we'll never have any problems with the rest of our heads. So when cost-saving restrictions are contemplated and employees are offered dental coverage or mental; the large majority choose dental.

Now there appears to be an interest in providing increased access to health care. We applaud the efforts but worry that we'll be excluded again.

Presently, only 15% of those needing mental health services are getting them. For many of them it is a question of cost as well as access. To increase that percentage and to alleviate suffering of those with mental illnesses we need coverage - coverage of inpatient, outpatient and partial hospitalization with provisions allowing trade-offs between different benefits so that treatment plans can be designed to better and more economically fit individual needs.

The pain of mental illness can be as real as physical pain and the suffering as great. The cost of the illness is also great. The cost to American society for all mental illness is estimated to be $73 billion each year. About half of this is from lost productivity and employment. If you consider just the savings on physical health care costs that mental health treatment can deliver, the policy question becomes not whether we can afford to include mental health services in health care plans, but rather how can we afford not to!

We thank you for allowing us to present our viewpoint and hope you will take it into consideration during your deliberations.

①

June 28. 1989

Dear Mr Don W. Reigle Jr.

My mane is Bernice Maxwell and I live at 846 Flowerdale in Ferndale Mich. 48220 I'm 55 years old.

I believe their should be a health plan and care for everyone, to feel good that if something goes worng with you, that you dont have to worry about paying it all or your family dont have to worry too

First let me say I thank God everyday for helping me go by each day, and still get by. I know it is not just for me to worry about insurance, because I also worry about the other people as well, because I know how hard it is to pay for Dr, or Hosptial or anyother medical bills. I am employed and still keep going everyday

②

I tryed to get insurance, but have been turn down because of my health problms. I don't think it is right for people to have to work and is turn down for health problems.

I believe if we have a good system were people can aford to pay for it, they could have something to full back on. I don't even have lif insurance to cover me good when I die. We only have the Free Press Insurance which isnt but 10¢ a week, but it helps alot. to know I got something.

I work as a mail sorter and packages and machin oper. and I make $5:75 a hour. I work for this type of work for 23 years. I started out at $1.60 a hour and the last 7 years has been the hardest for me in my life. My husband

was disabildy and he is coverd
on Medicare, but I had a hard
time on my insurance. We pay
part of my insurace off my payrod
and my Boss pay the other half.
Well in 1984 + 1985 + 1986 I had
to get a (lay) Lawyer for two years
just to pay the dr. & Hosptil Bills
and then I had to pay the Layer.
But for 1986 I want the Lawyer
to get my Bills payed and get his
pay, plus I think I should get some
thing for all the trouble my
Boss has made. And since
I have had no insurace becaus
of my (~~Condticon~~) (~~Conddicon~~ Condition). I
am enclosding a copy of my health
Condition, plus Im going deaf in
my left good ear I am deaf in
my right ear. But I live one day at
a time and play hard. I still have-
to say I thank God everyday
because there are more people in

④

worst shape than I, and I really can't see how noone can help them too. It's should have some thing set up were people can go and get help, and still don't have to worry about not paying the gas or elec. bills just to have pay the Dr or Hosptial Bills, or were some people don't get all their pills because it is too expensive.

I know I shouldn't have cut down or be without my medicine, but their were times when I just couldn't afford it. I know now I can't be without them or I couldn't be working like I do.

I thank you for helping us and also for everyone else. God Bless you and take care.

Sincerely
Mrs Bernice Maxwell

⑤

Nitrobid	6.5	10.88
Zantac	150mg	68.39
Lilraf	1 tid	6.47
Persantine	50mg	36.82
Caradizem	30 mg	44.17
Procardia	0 mg	42.20
Carafate		35.00
		$243.93

a month

That is an awful lot for pills but this what I have to take to get well."

AUTHORITY: 42 CFR 431.00 - 431.307 and 45 CFR 233.90
COMPLETION: Voluntary
PENALTY: Payment for medical exams and determination of Medical Assistance cannot be made.

MEDICAL EXAMINATION REPORT
Michigan Department of Social Services

Case Name: MAXWELL, BERNICE
Case Number: 1 25 33553 A
Date: 8-26-88

County	District	Unit	Worker	Other ID (If required)
63	02	47	05	

SECTION 1 – (To be completed by case worker)

1. Name of Client: MAXWELL, BERNICE
2. Social Security No.: 373328083
3. Date of Birth: 4-18-34
4. Client Address (Number, Street, City, Zip Code): 846 FLOWERDALE FERNDALE Mi
5. Sex: ☐ Male ☒ Female
6. Description of Last Job (Duration, When Discontinued, Why)
7. Usual Occupation
8. Client States That He/She Has the Following Disabilities (Date of onset of each): HEART + STOMACH
9. Case Worker's Signature: Bogoslaw
Date: 8-26-88

SECTION 2 – (To be completed by client)

TO EXAMINING PHYSICIAN: You are hereby authorized to release the information requested below to the Department of Social Services.

10. Signature of Client/Patient
Date

SECTION 3 – (To be completed by examining physician)

DOCTOR, PLEASE NOTE: This limited diagnostic examination is to assist the Department to determine the extent of our client's DISABILITY as related to EMPLOYABILITY. We would, therefore, appreciate your careful description of abnormal objective clinical findings that substantiate the symptoms and/or your diagnoses.

This examination is at our client's expense unless accompanied by a form DSS-93, Authorization – Invoice. Extensive clinical procedures and tests are not to be done unless prior authorization is given. Return completed Medical Examination Report and Authorization – Invoice promptly to the County Department of Social Services in the pre-addressed, stamped envelope.

11. HISTORY OF DISABLING CONDITIONS (Including date of onset of illness, injury and/or date of surgery)

Tender epigastric, chest pain, tachucardia

9-30-88

12. PHYSICAL EXAMINATION (Vital signs plus pertinent abnormal findings)

Height	Weight	Pulse Rate	Blood Pressure	Respiratory Rate
	143	65	112/70	

13. LABORATORY DATA (Pertinent abnormal findings or lab, radiologic and other diagnostic procedures). Attach copies if available.

Cardiac cath. shows over 30% stenosis of the right coronary artery. Thiallium scan shows decreased perfusion to the anterior wall of the left ventricle.

DSS-49 (Rev. 1-84) Previous edition obsolete.

The Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political belief.

14. DIAGNOSIS

ASHD, Peptic Ulcer Disease, Angina. COPD, and

Duodenal Diverticulosis.

15. CHARACTERISTICS OF IMPAIRMENTS (Check appropriate terms)

STATUS: ☐ Improving ☒ Stable ☐ Deteriorating

PROGNOSIS: ☐ Remediable by Treatment ☒ Improvement by Treatment ☐ Not Remediable ☐ Terminal

16. PHYSICAL LIMITATIONS ☐ No limitations ☐ Limited (indicate on chart below)

A. LIFTING/CARRYING

	Never	Occasionally	Frequently
Up to 5 lbs.	☐	☒	☐
6 - 10 lbs.	☒	☐	☐
11 - 20 lbs.	☒	☐	☐
21 - 25 lbs.	☒	☐	☐
26 - 50 lbs.	☒	☐	☐
51 - 100 lbs.	☒	☐	☐

STANDING/WALKING & SITTING

Based on an 8 hour work day how many hours, in your estimation, can the following activities be tolerated by our client?

Standing ______ hours/day
Walking ______ hours/day
Sitting ______ hours/day

B. Additional functional limitations (i.e. driving, bending, climbing, exposure to dust, fumes etc.).

17. EMPLOYABILITY ☒ Employable ☐ No limitations ☐ Limitations as noted above

☐ Unemployable: ☐ 60 days or less. ☐ More than 60 days

18. MEDICATION (Please specify type, dosage and schedule and potential side effects)

Librax 1 tid Nitrobid 6.5 mg 1 qid

Persantin 50mg 1 tid Carafate 1mg 1 bid

Procardia 10mg 1 qid Zantac 150mg 1 bid

Cradizem 30mg 1 qid

19. RECOMMENDATIONS (Please indicate what additional diagnostic studies or treatment is needed. If referral to specialist is advisable, please specify type.)

20. Can our client meet his/her needs in the home? ☒ Yes ☐ No

If No, what assistance is needed? ______

21. Will you be treating our client? ☒ Yes ☐ No	Number Visits Per Month once every 2 months	Number of Months of Treatment 12

REMARKS: Please use additional sheet for remarks and expansion of any of the above items. Thank you.

22. Physician's Signature Ibrahim MD	23. Printed Name of Physician Fikry F. Ibrahim M.D.	24. M.D. or D.O. (Specialty, if any) M.D.
25. Address 20825 Mack Ave. Grs. Pte. Wds. MI. 48236		26. Date of Examination 9-30-88

SUSAN MENGHINI
15861 HORGER
ALLEN PARK, MI 48101

Senator Riegle, 6-27-89

As a Registered Nurse at Detroit's Harper Hospital, I have seen first hand the results of a lack of health care for the poor. It is not unusual for us to see people admitted with disease process out of control, which, if caught and treated early, are curable or at least, managable.

In a society that can afford to spend millions on sports stadiums, movies, clothes, cars and other luxeries, a health care system cannot be excluded from the budget. It is a shame that the poor + elderly are swept under the carpet while those with means are offered the finest care in the world -- right here in Detroit We at Harper hospital, are striving to offer equal care to all. Please, Senator do what ever it takes to assure the right to wellne to everyone. Thank-you.

Sincerely,

Susan Menghini, R

4VN Harper Hospital
3990 John R.
Detroit, Mi 486

METEA
COURT

A Planned Community for Senior Citizens

809 RYNEARSON ROAD
TELEPHONE (616) 695-9842 • BUCHANAN, MICHIGAN 49107

June 27, 1989.

Donald W. Riegle, Jr.
United States Senator
Wayne-Monroe
1850 McNamara Federal Bldg.
477 Michigan Ave.
Detroit, Michigan.
48226

Dear Senator Riegle:

I thank you for your letter dated June 20, 1989; on the Senate Finance Committee on Health hearing you will be having on June 28, 1989. Due to previous commitments I will not be able to attend. I would like to enlighten you to the situation I have at the present time.

We have a very nice apartment complex (MSHDA) project that is comprised of senior citizens, handicap, & disabled tenants. Due to the continuing paper work I must do on my tenants; 90% of them are on a very much fixed income. The other 10% through a lot of very hard work during their younger years are in somewhat better shape financially.About 50% of the above 90% have had to drop their health insurance policy's this past year due to the ever increasing cost of insurance premiums. They don't have enough money to have a home,eat,and make premium payments on health insurance. Thus insurance must go, which puts them in great fear of becoming seriously ill. They are afraid that medcare and medicade would not cover the costs of becoming ill an in the end they fear they might be left without a penny and possibly homeless.

I would hope that through your efforts and with the help of other concerned Senator's and Representitives; that our United States Government could in the future come up with a program that would cover the ever increasing medical costs in this country and help relieve the ever increasing pressure on the minds of both the insured and uninsured.

EQUAL HOUSING OPPORTUNITY

METEA
COURT

A Planned Community for Senior Citizens

809 RYNEARSON ROAD
TELEPHONE (616) 695-9842 • BUCHANAN, MICHIGAN 49107

(2)

We seem in the United States to be able to go into more national debt every year for every known reasons and causes. Why not a health program to cover those that can't afford health insurance? For that matter, why not a program to cover all Americans? It seems that the people of the United States has had a great deal to do in the effort to make the United States the great country in which we live.

Please do anything an all that you can on the increasing health care costs in this country. We would all appreciate the help.

Thank you very much for your time,your consideration, and for the work your trying to do on the problems surrounding health care for both the insured and uninsured.

Thank you.

Sincerely;

John D. Harte

John D. Harte
Resident Manager
METEA COURT APARTMENTS

EQUAL HOUSING OPPORTUNITY

June 30, 1989

Ms. N. Michalski
330 E. 13 Mile Road #4
Madison Heights, MI 48071

Senator Donald W. Reagle, Jr.
SOUTHEASTERN REGIONAL OFFICE
Century Center Building
30800 Van Dyke
Warren, MI 48903

Dear Senator Reigle:

This letter is being sent to give you my thoughts of opposition towards the exercising of a "hearing" regarding a "problem" to access to affordable health care. There are many affordable health insurance plans where information may be sought and attained through the Yellow Pages in the telephone directory or through resources at the library. I think the Senate Finance Sub Committee on Health may be leading individuals to believe they may have a problem that they themselves cannot solve when in todays' modern society affordable health insurance can easily be attained at a very modest rate. Health insurance vs the accessability to the easily attainable material wants and needs may be a dominent factor as to why many people do not have health insurance, and may not have been educated in school or through their domestic background have never been taught where health insurance is a priority that is understood when you become of age to be employed.

The thoughts and concerns for the helping those in need of Health Insurance is : (1) priorities and importance of the need of health insurance; (2) the advantages of health insurance; (3) the variety of health insurance plans, the many different coverages attainable and their cost. It seems that in the society we live in that in some instances some individuals believe that **the government is obligated to extend itself with a helping hand when their are many opportunities for employment** today more so than it has been for a number of years.

People must show and take initiative to help themselves whenever possible so that they may continue to get ahead in life and endure the satisfaction and gratification that comes from helping yourself. Too many citizens are not aware of the importance of how they could be of help to the government and the social-ogical society we live in today. There seems to be a lack of knowledge regarding how persons could and should get involved in helping and supporting the decisions that the government proports. Citizens of this country should be more aware of how taxes are put to use (the overall useage) and have the opportunity to have definite ideas and control in the decision making process on all things that may affect them directly or indirectly and are made aware of how their decisions and indecisions will maintain, change or contribute to the system that is to be affected.

In this time we live in today with the opportunities of private business, accessible knowledge of attaining guidence from numerous employment agencies, the wide spread transportation system we have, most people today have very few reasons may be lack of knowledge or knowing where they can get iformation regarding affordable health insurance. It is a case of misunderstanding priorities and need; if the government were to support the lack of knowledge of an issue such as this what future support will it give on other issues where priorities and need are not necessarily written in black and white. It seems as though when and if the government supports to help persons who are in need of financial support they should consider how and what effect it is going to have on the persons in need and other taxpaying citizens. Would the government be supporting people to be dependent upon it and at the same time take away opportunity and initiative for these same people in other sectors of life? I do not think that there is a real problem with persons being able to get health insurance that would be suited to their needs, unless they've been in an accident and are in a position where they need continuing health care, the options today are more widespread than ever before.

Sincerly,

Noreen C. Michalski

Record of Payment

Policy Number

[redacted]

Due Date

05-11-89

Date sent ____________

Amount $ ____________

Physicians Mutual Insurance Company
2600 Dodge • Omaha, NE

IMPORTANT: Is your name and address correct as shown? If not, please print correct name/address on back of your notice.

Detach this stub for your records

Physicians Mutual Insurance Company
2600 Dodge • Omaha, Nebraska

PREMIUM NOTICE

DUE DATE	PREMIUM DUE	
	MONTHLY	ANNUAL
May 11, 1989	$8.55	$94.05

BE SURE TO MAIL BEFORE DUE DATE

5 06

POLICY NUMBER

[redacted]

[redacted]

YOU SAVE $8.55 BY PAYING ANNUALLY -- ONE MONTH FREE!

N139-3

Please mail your payment promptly with this notice. Thank you.

Please make check or money order payable to Physicians Mutual

011409759506000085500094057529

WRITTEN TESTIMONY
OF
MICHIGAN CATHOLIC CONFERENCE
ON
ACCESS TO HEALTH CARE FOR THE UNINSURED

The Michigan Catholic Conference, the public policy arm of the Catholic Bishops of the state of Michigan, welcomes the opportunity to offer our reflections on an issue of critical importance to our nation, namely, access to health care for those who are uninsured. The interest of the Michigan Catholic Conference in this important agenda item flows from its belief in the inherent value of each individual person and the right that person has to basic health care. The ability to receive health care has been influenced to a great degree over the last three decades by major changes which have affected the delivery of care for those in need.

During the period from the end of World War II until the institution of Medicare and Medicaid, indigent Americans depended principally upon charity care. Hospitals and physicians provided necessary core on an ad hoc basis insofar as they were able to carry the cost from surplus revenues, barter, or even additional work. Although some physicians and administrators fantasize about returning to those "happier" times, they forget that the kind of care provided then was typically low tech, low cost and differentiated by class (e.g., the poor were hospitalized in large wards with little amenities or attention).

With the advent in 1965 of federal and state entitlement programs (Medicare, Medicaid, etc.), a revolution began in American health care. The government, through allocation of tax revenues from all Americans, guaranteed that all citizens would receive the same high quality of care regardless of ability to pay. For the first time in our national history, we committed ourselves to abolishing multiple-tier health care and replacing it with a uniformly best-quality system for all. Unlike Western European countries, we chose to accomplish this by external funding of existing delivery agents and systems (fee-for-service reimbursement). Massive new hospital construction programs ensued. Multiple patient wards were abolished and replaced with private and semi-private rooms. The increase in high-tech care along with the explosion in malpractice litigation gave way to a strong inflationary influence. Generally, however, everybody was happy: doctors, hospitals, nurses, and patients. Because of generous government programs, indigent, uninsured patients were relatively few. What few existed found access to care through excess hospital revenues.

We entered a new era of health care cost containment during the Reagan administration when social programs were cut.

With the introduction of prospective payment for Medicare in 1982-1983 as an attempt to further reduce costs, the administration stimulated a fundamental transformation in the health care system. Private insurers and state governments simultaneously attempted to reduce costs. The specifics of method are unimportant here. The end product has been a significant reduction in available monies to pay for care, a substantial contraction within the industry, especially in hospitals, and a tendency to eliminate the indigent and low-income employed from coverage, both public and private.

Thus, while the customary source of monies for support of care of the indigent and uncompensated dwindled to almost nothing, the number who need assistance for all or part of their health care costs have increased beyond any expectations. The current estimate for the number of uninsured in our country is in upwards of 37 million people; two thirds of whom are workers or are the children of workers. In Michigan, the number of people without any kind of health care insurance is over one million people -- roughly 11 percent of the state's population or one in nine persons.

It seems ironic that in the richest country in the world, and one which is enjoying the longest lasting peacetime economic expansion in its history, that millions of its citizens cannot even obtain decent affordable health care. A basic reform in our country's health care system is needed. It is justified on grounds of equity, overall health of our population, and total cost to society. Programs which fund care specifically for indigent patients are inadequate, because they are susceptible to being cut when felt to be too expensive. Two-tiered care is unacceptable because separate but equal has always been untrue. Separate systems are easily allowed to decay. If everyone has to use a system, everyone is committed to keeping it strong.

The health care industry is in a state of profound change. A significant challenge is formulating public policy which can guide these changes. This guidance is needed so that we as a nation can once again return to the ideals that all citizens be guaranteed to receive the same high quality of care regardless of ability to pay. Both the problems and the solutions are human ones. The question then is, what values will guide our discussion and our decisions as we seek to formulate solutions? Our answers will either enhance the dignity of those individuals who are currently unable to receive care and resolve our current problems or will undermine human dignity and permit our problems to overwhelm us. The Michigan Catholic Conference hopes that a creative new beginning can be made to develop a national policy to enhance the basic dignity and rights of all people who are in need of quality health care. We call for a new national policy to aid the uninsured in our society not simply for what it can mean for those individuals, but also for how it can strengthen the overall health of the nation.

The Michigan Catholic Conference urges this subcommittee and the Senate as a whole to consider this issue with a full spectrum of possibilities: from community based health care systems to a national health insurance program. This discussion must include both providers and consumers. The Michigan Catholic Conference is committed to participate in this debate with a view to adopt a policy that will enhance the health care of all American citizens.

Michigan County Social Services Association

OFFICE:
935 North Washington Avenue
Lansing, MI 48906
517 371-5303

1988-89 OFFICERS AND
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June 26, 1989

The Honorable Donald W. Riegle, Jr.
United States Senate - Wayne/Monroe Office
1850 McNamara Building
477 Michigan Avenue
Detroit, Michigan 48226

Dear Senator Riegle:

We wish to submit this letter as testimony for your June 28, 1989, subcommittee hearing on health care.

MCSSA has been extremely concerned about the issue of health care for the uninsured and about erosion of Medicaid benefits for those who qualify for coverage. These issues have been legislative priorities for us on the state level for the past two years and we have been actively advocating for access to care.

MCSSA is an association of directors of local offices of the Michigan Department of Social Services and, with our medical care facility and worker affiliates, number approximately 400 members. MCSSA is very active within the state legislature and with the American Public Welfare Association in advocating for our client population and in articulating needs for programs and funding.

The issue of access to adequate health care for all citizens remains a top priority for our association. Our 1989 priority statement is attached for your review. In addition to the issues set forth in that statement, there are two areas which we see as critical on the federal level:

1. Development of a needs-only (financial) standard and simplification/elimination of categorical requirements.

2. Federal financial participation for health services, specifically Medicaid, at a level which realistically provides basic medical, dental, and vision coverage for eligibles.

As efforts to improve health care access for the uninsured go forward on the federal level, MCSSA would like to be involved in developing and supporting policy which fills this gap.

Sincerely,

Cynthia Maritato

Cynthia Maritato
Chair
Health Services Committee

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Attachment

MICHIGAN COUNTY SOCIAL SERVICES ASSOCIATION

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HEALTH SERVICES

Priorities

1. Preservation of basic medical, dental and vision coverages for all department clients who meet categorical standards.
2. Advocacy for basic medical, dental and vision coverages for uninsured state residents.

The Problem

The Michigan Department of Social Services has found itself in an escalating debate over provision of health benefits to Michigan citizens. There is the problem of preserving existing Medicaid coverages to eligible recipients. In an effort to check the staggering advance of medical care costs, cost containment is being addressed on many fronts via prospective payment systems and managed care plans, among others. While more elaborate treatment and technology extends life expectancy both at birth and in old age, provision of neo-natal and long-term care has a high price tag. In addition, one million of Michigan's population have no health coverage of any kind.

Facts

1. In 1987, the overall bill for health care in the United States came to $500 million, or 11.1% of our gross national product.
2. In 1987, there were 1.1 million Medicaid recipients in Michigan. Over half of these recipients were under the age of 20. Costs for care were:

   o inpatient hospital - $567 million
   o outpatient hospital - $133 million
   o long-term care - $402 million
   o physicians - $171 million
   o prescribed drugs - $129 million

3. In 1987, Michigan spent over $56.5 million for resident county hospitalization. Generally, these costs were for inpatient treatment only. The cost per hospital day was typically between $450 and $650 including doctor's fees.
4. In Michigan, over one million people (11% or one in nine of the state's population) are uninsured. Uninsured means not covered by Medicaid, Medicare, CHAMPUS, or employer or other group health plans.

- o Nationally, 37 million are uninsured.
- o Of the one million uninsured in Michigan, 31.4% are adults working either full or part time and 34.8% are children up to 19 years old. This is 66.2% of the uninsured population.
- o Minorities suffer a 15% higher uninsured rate.
- o The lower the income and family size, the higher the uninsured rate. For instance, 23.7% of single individuals with annual income under $7,000 are uninsured as compared to 12.2% of four-person families with incomes under $12,500.

5. Detroit's 1986 infant death rate was 20.5 deaths per 100,000 births. This is nearly twice the national rate of 10.6. The Medicaid program now covers low income pregnant women and their unborn children. Both DSS and the Department of Public Health operate preventive health and nutrition enrichment programs but much remains to be done in terms of outreach and education.

Position

The Michigan Department of Social Services and the people it serves are facing a crisis in terms of financing medical care and making it accessible. Michigan's attempts to curb social services' costs, coupled with cuts on the federal horizon (Gramm-Rudman legislation and deficit reduction efforts), have, thus far, resulted in targeting the Medicaid budget for a significant reduction. Meanwhile, health costs continue to advance and employers are responding to this by reducing coverage, controlling reimbursement, raising co-pays, and not covering certain employees. In this environment, two things happen to the uninsured group: 1) they become users of public health care systems (Medicaid, RCH, GA Medical, Hill Burton, etc.) and, 2) they go without care for both acute and chronic problems often until the condition results in inpatient or emergency treatment, the most expensive levels of medical care. Counties and local governments are currently struggling with financing medical care to this group. Cuts in existing Medicaid coverages will fuel this crisis to a meltdown point.

As employees and administrators of the department, as social services board members, as concerned citizens and as taxpayers, we must work for legislation which provides basic health care as a right for all state residents. By basic services, we mean medical services necessary to treat acute and chronic conditions and which intervenes at the least expensive point of treatment. Fundamental to providing health care is an appropriation level that assures availability of coverage through direct reimbursement to providers of care.

Further, we should work to eliminate categories of need (age, disability, family composition) as a basis of eligibility and move toward a needs-only (income and asset test) standard which would encompass the working poor.

Employers can be encouraged to offer and contribute to the cost of health care coverage for their employees through legislated incentives. Health insurers in other states have established their own programs to cover the uninsured and similar activity should be encouraged in Michigan.

The Michigan County Social Services Association sees access to basic health care as a bottom line responsibility of the department and one that must be funded first, not last. When people are sick, cannot see well or have major dental problems, they cannot work, cannot learn, cannot have healthy babies, and the likelihood that they will ever become self-supporting is diminished. Adequate and available health services can be cost effective in assisting citizens in our state to develop self-sufficiency attitudes and lifestyles.

MICHIGAN HOME HEALTH ASSEMBLY
4990 Northwind Drive ▪ Suite 220 ▪ East Lansing, MI 48823
(517) 332-1195 ▪ FAX (517) 332-1196

June 28, 1989

TESTIMONY BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

The Michigan Home Health Assembly thanks you for this opportunity to speak to the issue of access to health care. As providers of service in the home setting, everyday we witness first hand the effects of a changing health care delivery system. Acute care institutions are truly providing "acute" care. Continuing care beyond the acute phase of illness is provided in the growing intervening and long term care arena. Home health, as a primary component in this arena, has felt the effects of this evolution with a significant growth in demand for service. As you review access to care, we wish to ask that you include home health as a covered benefit .

As we all know, business in our society is driven by supply and demand. Demand for Medicaid home health in Michigan has increased 71% over the past four years. Senator Riegle, you have demonstrated your commitment to assuring health care coverage for children by introducing the Medicaid Children's Health Improvement Act of 1989. Within the aforementioned 71% increase in demand for service is a 107% increase in demand for service for those under age 21. Paradoxically, the number of home health providers is stagnating. The reason for this tenuous state of affairs is reimbursement.

Home health is primarily a cost capped reimbursement system. In 1988, approximately 90% of home health agencies in Michigan had costs exceeding Medicaid reimbursement levels. Due to the cost based reimbursement system, losses cannot be offset through a diversity in payor source. Non-compensated care, including losses from Medicaid, can only be provided by utilizing limited reserves or community funding.

Neither of these alternatives is meeting the needs of the agencies to assure even short term business viability. Therefore, the only option remaining is each agency limiting the numbers of patients who are under or uninsured. As believers in health care available to all, this does not sit well with home health providers. As an industry, we are committed to finding solutions to this growing problem.

This great nation of ours is making significant strides toward addressing the needs of the uninsured and the underinsured. Senator Kennedy and Representative Waxman have introduced Health Benefits for All Workers Act (S768) (HR 1845). However, in both pieces of legislation, home health is omitted as a covered service. Please take a long hard look at home health care as we affirm our commitment to the American people by assuring health benefit coverage available to all.

michigan
hospital
association

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Spencer C. Johnson
President

July
Six
1 9 8 9

The Honorable Donald W. Riegle
United States Senate
Central Office
705 Washington Square Building
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

Enclosed please find written testimony of the Michigan Hospital Association (MHA) on the access to health care problem. The MHA would like the testimony to be included in the public record for the Senate Finance Subcommittee on Health hearing which was held June 28 in Southfield.

The MHA appreciates your attention on the issue and as our testimony indicates, this problem cannot be allowed to fester. Thank you for the opportunity for input. I hope our testimony is helpful in your deliberations in the Senate.

Sincerely,

John Griffin
Director
Government Affairs

MHA TESTIMONY TO SENATE FINANCE SUBCOMMITTEE ON HEALTH

The Michigan Hospital Association appreciates the opportunity to provide testimony to the Senate Finance Subcommittee on Health on the issue of access to health care. The hospital industry is alarmed at the current access-to- health-care problem and the worsening of the problem that looms on the horizon. Over 1 million Michigan residents have no health insurance. Michigan hospitals' uncompensated care load has increased from $239 million in 1986 to $342 million in 1987. In 1980, the figure was $92.5 million. As you can see, uncompensated care is increasing at an alarming rate.

As the amount of uncompensated care increases, hospitals' ability to finance uncompensated care has been greatly diminished. A study by Hal Cohen Incorporated shows Michigan hospitals on the aggregate are reimbursed 79 cents on the dollar from

Medicaid for the actual cost of delivery of care. A similar study conducted by the accounting firm of Ernst and Whinney concludes that Michigan hospitals are reimbursed 89 cents on the dollar for Medicare services. Third-party payors insist on paying only for the services they purchase, thereby reducing the cost shifting opportunities hospitals have traditionally used to underwrite losses from uncompensated care. Clearly, some action must be taken to ensure the providers of health care are able to care for all citizens. The health care system can no longer absorb losses from government reimbursement sources in addition to providing increased amounts of uncompensated care.

The Michigan Hospital Association believes a system of universal health care coverage, which results in all citizens being sponsored by a private or public program, should be instituted. Every individual has a right to a basic health plan. A system that accomplishes this will eliminate the hidden tax on private payors and will distribute the burden of providing health care benefits more equitably to all employers, along with the state and federal governments.

Does the status of access to health care warrant sweeping changes that will bring about a system of universal coverage? We think so. As this hearing is taking place, the Michigan Hospital Association membership is attending its annual meeting. One of the topics on the agenda is "The Vision of Health Care in the Year 2000." Our vision is a system of universal coverage where no citizen is uninsured for health care coverage. The purpose of Medicaid and Medicare is to ensure health care for the poor, the elderly, and the handicapped. For nearly 25 years they have achieved great successes in their goals. Yet slightly over 17 percent of all Americans, 37 million, remain uninsured. The largest portion of the uninsured is the working poor, and employers providing health care benefits to their workers are unfairly paying a larger health care bill so hospitals can absorb losses caring for the uninsured, many who are employees of other firms.

The Michigan Hospital Association believes the time to act is now, before the access problem worsens. Basic health care should be available for all citizens. Addressing the health care access problem is no easy task. But we believe, most everyone would agree that it needs to be done.

Thank you.

21700 Northwestern Hwy.
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Southfield MI 48075-4999
(313)552-8666

A District Branch
of the American
Psychiatric Association

MICHIGAN
PSYCHIATRIC
SOCIETY

June 27, 1989

Senator Donald W. Riegle, Jr.
United States Senator
Washington, D.C. 20510

Re: Health Care for the Uninsured

Dear Senator Riegle:

The Michigan Psychiatric Society's testimony on health care for the uninsured follows.

The Michigan Psychiatric Society supports legislation that would assure access to health care for the 37 million Americans--including 12 million children--who do not have adequate or regular access to health care. The Society also urges that any legislation include assurance of coverage for those with mental illness or those who have reason to seek mental health services. This mental health coverage should have limitations no more restrictive than those for other health conditions.

The current access problem for working people and their families in need of mental health services is far worse than for those seeking physical health care. According to data from the most recent National medicare Care Expenditure Survey, 82 percent of all persons with private health insurance were covered for inpatient care of mental health conditions compared to almost universal coverage of other inpatient hospital care. The difference was substantial as well for physician care: 71 percent were covered for outpatient physician services for mental conditions, compared with 83 percent for medical conditions. Further, the inpatient and outpatient benefits were far less comprehensive. Maximum benefits were lower, deductibles higher and the percentage reimbursed substantially smaller. Further, many persons with serious mental illness were denied health insurance coverage entirely because many insurance carriers exclude coverage of pre-existing conditions.

Mental illness knows no class, sex, race or age limitations. Recent data from the National Institute of Mental Health provides a picture of the breadth and impact of mental illness in the United States, particularly among the working age population.

- In any six month period, approximately 29.4 million adult

Americans (18.7 percent of the population) suffer from one or more mental disorders ranging from mild to serious but for whom medical intervention is appropriate. People aged 25 to 44, people in their prime working years, accounted for the largest percentage of admissions to inpatient psychiatric services in 1980.

- Suicides by persons under age 35 was the third leading cause of death for this age group in 1982 and between 1958 and 1982, the number more than doubled.
- The locus and nature of mental health care has changed markedly over the 14 years from 1970 to 1984. Inpatient beds per 100,000 people decreased 56 percent, but inpatient treatment episodes decreased only 3 percent, indicative of significantly shorter inpatient stays. Concomitantly, outpatient care in organized care settings (i.e. excluding patients served by private practitioners), increased over 135 percent per 100,000 population during the same period.
- In 1980, total expenditures for mental health care were estimated to be between $19.4 and $24.1 billion, representing about 8 percent of all expenditures for health care.

Any legislation should prohibit insurance carriers from excluding people from coverage because of pre-existing conditions. The presence of a chronic handicap, such as mental illness, has been used by carriers to deny both coverage and reimbursement for mental illness and other chronic disorders and conditions.

Any legislation should permit a "trade-off" between days of hospitalization and outpatient visits, as long as the insurance plan provides some hospital inpatient care and some outpatient care.

Legislation to ensure health benefit coverage, including mental health coverage, for all Americans would represent the most important advance in national health policy since the passage of Medicare and Medicaid in 1965. It would provide access to health care for 37 million persons now without such access.

Sincerely,

Sheldon N. Siegel, M.D.

Sheldon N. Siegel, M.D
President

SNS/mc
Benefits.Ame

Ψ MICHIGAN PSYCHOLOGICAL ASSOCIATION
CLINICAL DIVISION
29446 Ravine Drive • Livonia, Michigan 48152 • 313-525-0460

June 25, 1989

The Honorable Donald Riegle
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

In reply to your letter requesting testimony at this Senate Finance Subcommittee hearing, we respectfully submit the following:

Regarding the Uninsured

The Kennedy-Waxman proposed Basic Health Benefits for All Americans Act (S. 1265) is an essential step in assuring that all working Americans will receive at least minimally adequate health care. Apart from the simple humaneness of this legislation, it is also likely to be good for the economy in the long run, when one considers the enormous cost of failing to treat health problems in their early phases, which is what 37 million uninsured working Americans routinely do.

THE IMPACT OF INADEQUATE INSURANCE

The major problems that later develop from these untreated conditions have not only major personal cost to the individual but lead to enormous costs to their families; to their employers; to private providers, hospitals, and other community health institutions which must eventually serve them on a pro bono basis; and to the economy which must absorb the lost productivity and social welfare costs. A recent study found that up to one third of hospital admissions could have been avoided by earlier access to care.

Approximately two thirds of the uninsured are members of families in which at least one member of the household works full-time. Children constitute one third of the uninsured. An additional sixty million Americans have some insurance but are underinsured. They have no catastrophic cap on their vulnerability to out-of-pocket health care costs and are potentially at risk in the even of serious illness. According to the Department of Health and Human Services, about 2.5 million families annually face catastrophic, out-of-pocket health care expenses exceeding $3000.00.

AMERICA'S "OTHER" HEALTH PROBLEM

But what is true for the physical health needs of American workers and their families is equally true for their mental health needs. It has been estimated that 20% of the population have mental health problems requiring professional attention at some time. As psychologists who treat insured and uninsured workers on a daily basis and as members of the Michigan Psychological Association--Clinical Division Insurance Committee, we are constantly exposed to the agonizing decisions that both the uninsured and mental health service providers face in struggling to make vital services available to those without any or without adequate mental health coverage.

Many psychologists in Michigan have more than once found it necessary to recommend that an individual in acute need of treatment seek hospitalization or inpatient day treatment rather than outpatient psychotherapy. Although outpatient psychotherapy is often more effective and always considerably less costly and less restrictive on patients' freedom, many patients have insurance coverage which only covers inpatient treatment or only treatment by psychiatrists (who, as a group, are often under considerable pressure from hospitals where they have staff privileges to keep up the volume of inpatient admissions).

THE "OSTRICH POLICY"

There is in this country an "ostrich policy" about the mental health needs of American workers. Both employers and insurance companies seem at times to hope that mental health problems will simply go away. Most HMO, PPO, and Managed Care policies place severe and often grossly unrealistic restrictions on outpatient psychotherapy benefits and commonly restrict choice of provider to a small group of para-professional "counselors" who have limited training.

These programs also often require patients to assent to gross violations of their confidentiality in order to use their benefits. Many of our patients have chosen to pay for treatment out of pocket rather than submit to these demands for quasi-public exposure of intimate details of their private lives.

State-mandated employee mental health benefits and freedom of choice regulations (currently on the books in 42 states) are routinely circumvented by a growing number of self-insured corporations under the ironically inappropriate shield of ERISA. At the same time, individual health insurance policies with coverage for relatively inexpensive outpatient psychological and psychiatric services are all but impossible to obtain for individuals who are neither self-employed nor covered by an employer plan that offers such benefits. Most lower income clerical, service, and manufacturing workers and students fall into this category.

THE HIDDEN COSTS OF THE "OSTRICH POLICY"

Nevertheless, there is abundant evidence that both the social and economic costs to families and to businesses of untreated mental health problems are an enormous drain on both private and public resources. Studies of outpatient psychotherapy have shown it to be enormously cost-effective, not only in personal benefits to the individual being treated but also in terms of substantially reducing overall health care costs and reducing the billions of dollars of lost productivity due to mental health problems.

Those businesses that prudently already provide adequate coverage for their workers pay a high price for the failure of other businesses to do their part of fulfilling this critical social responsibility. As Robert Crandall, Chairman of American Airlines, said, "Companies like ours pay for health care twice--once for our own employees and then again, via taxes and inflated health insurance premiums, for the employees of those businesses who don't provide benefits for their own people."

The 60% of small businesses who currently enter the insurance market pay unnecessarily high costs because of the current fragmented, inefficient insurance system for small businesses produces high sales and administrative costs, inadequate market power to organize efficient delivery of care, and excessive, costly switching between insurance companies. Small businesses with any employees in poor health or a history of psychological problems often cannot purchase insurance at any price. It has been estimated that the Kennedy-Waxman legislation may save small businesses who currently insure their employees as much as 25% and will provide them with guaranteed access to health insurance coverage without pre-existing condition exclusions through the regional insurer program.

TOWARDS FAIR COMPETITION AT HOME AND ABROAD

The Kennedy-Waxman legislation will assure fair competition between businesses that insure their workers and those that do not. It will enhance international competitiveness since the firms that are at the cutting edge of international competition already insure their workers and are paying additional costs to subsidize the health care of workers in firms that do not provide insurance.

Finally, by providing for care by all appropriate health care providers in the various professions (e.g., psychology as well as psychiatry), it overcomes the misuse of ERISA regulations by self-insured corporations to circumvent state freedom-of-choice laws and ensures a vital and cost-effective level of clinical practice in the provision of essential health services.

IMPACT ON THE WORK FORCE

Although some businessmen who have not seen fit to provide adequate health insurance for their employees have argued that S. 1265 will increase labor costs and thus reduce employment, the effect can in fact be expected to be minimal. According to Professor Gerard Adams, who analyzed the proposal using the well-known Wharton Econometric model, there should be **no net effect on employment.** The highest estimate of impact on employment, from Data Resources, Inc. found at most a minimal increase in the unemployment rate of one tenth of one percent.

Moreover, the reduction in massive costs (running into billions of dollars a year) of preventable occupational disabilities and inefficiencies attributable to untreated physical, emotional, family, and substance abuse problems will more than compensate for any adverse impact on labor costs associated with this legislation. S. 1265 will also reduce welfare dependency by removing one of the principal barriers to employment--the loss of medical insurance through Medicaid.

We urge you and the members of the Subcommittee to recommend passage of S. 1265. By so doing, you will help assure quality physical and mental health services for millions of uninsured and underinsured workers; ensure efficiency and cost-effectiveness by maintaining competition among providers within the health care field; and provide major flexibility for employers and employees, allowing workers to choose among a variety of health care settings and providers.

Ensuring Adequate Mental Health Care for the Elderly: Regarding Medicare Part B

While dentistry, optometry, podiatry, chiropractic, occupational and physical therapy, and nurse midwifery have all long been included in Medicare, psychology has been unaccountably absent. Senate Bill 100, sponsored by Senators Rockefeller and Inouye, provides for the direct reimbursement by Medicare of doctoral-level psychologists for mental health services for the elderly within the scope of their state licensure.

THE PROFESSIONAL TRAINING AND EDUCATION OF PSYCHOLOGISTS

In Michigan, as in most states, a licensed psychologist must earn a doctoral degree from an approved university graduate program (usually comprising five to seven years of post-graduate study in psychology). Such study typically includes (but is not limited to) courses in the cognitive, biological, social, and emotional bases of behavior; all theories of normal and abnormal behavior; and ethics and professional standards.

Psychology graduate students must demonstrate competence in research design and methodology; they must undergo intensively supervised training in assessment and treatment of mental and emotional disorders; and they must complete an original scientific contribution to the field.

Psychologists must also complete an internship of at least one year full-time in addition to prior supervised practicum experience. While state licensing laws vary in some particulars, in general, psychologists must also complete one or two additional years of post-doctoral supervised treatment experience and pass a national licensing examination.

Overall, according to the National Research Council, psychologists have an average of 7.1 years training at the doctoral level in mental health care (in addition to four years undergraduate study--**more than any other profession, including psychiatry.**

Licensed psychologists practice independently of physicians under state laws in all 50 states. Care by psychologists is covered by nearly all private insurers and all federal health programs other than Medicare.

WHY PSYCHIATRISTS CAN'T MEET THE NEED BY THEMSELVES

The inclusion of psychologists' services in Medicare is of critical importance in meeting the mental health needs of the elderly. Although psychiatrists have argued that they can handle this task alone as the exclusive providers of mental health services, such a policy is not only inequitable and inefficient; it is simply unworkable.

It is extremely difficult for the elderly in this country to obtain psychiatrists' services owing in large part to the fact that there are no psychiatrists at all in **nearly two thirds** of the counties in the United States. In nearly half of Michigan's 83 counties there is not a **single** psychiatrist available. Fully licensed Michigan psychologists, on the other hand, locate their primary practice in at least 75% of Michigan's counties. By limiting access to only psychiatrists, current Medicare regulations are ignoring the mental health needs of Michigan's elderly nearly everywhere one looks, particularly in northern and western Michigan and in the Upper Peninsula.

As for residential care, as the **Psychiatric Times** (March, 1989) reported, "Most psychiatrists have never set foot in a nursing home (p. 19)." Yet, suicides in nursing homes are four times higher than in other settings.

WHY THE ELDERLY CAN'T AFFORD THEM

Moreover, even in those areas in which psychiatrists are available, the majority of psychiatrists do not typically include many senior citizens in their practice. Their fees for outpatient treatment tend to be substantially higher than psychologists' fees, thus limiting their accessibility to those on fixed incomes, who must pay a 50% co-pay on outpatient fees covered by Medicare.

Specifically, surveys show that outpatient services of psychologists are 14 percent less expensive than those of psychiatrists and are often preferred by consumers. When psychiatrists are forced to compete with psychologists, psychiatric fees decrease between 9 and 12 percent. Thus, in spite of increased utilization, fees paid by Medicare and co-pays paid by seniors for outpatient psychotherapy would be substantially reduced by allowing competitive, independent participation by psychologists under Medicare.

THE REAL STORY: THREE MONTHS OF TRAINING ISN'T ENOUGH

Family physicians are the only available resource for 75% of the elderly who seek mental health care under Medicare. These non-specialists in mental health care have been shown to be disastrously ineffective in taking up the slack. In most medical schools, not a single course is taught on geriatric medicine, and few family physicians receive extensive training in assessing psychological capacities and problems.

Any licensed graduate of a four-year medical school, typically with **less than three months of training** in diagnosing and treating mental disorders, can offer mental health services under Medicare. He or she may even choose to specialize in psychiatric treatment without any additional training or residency. Thus it is perhaps not surprising that, according to recent estimates, 40 to 70% of the elderly's mental health needs are misdiagnosed by physicians within the current Medicare system.

RAMPANT MISDIAGNOSIS--A COSTLY ERROR

Researchers estimate that 80% of the mental health needs of the elderly are not being met by the present system. One out of every four elderly persons has a disorder that requires mental health care. Often treatable but misdiagnosed cognitive and emotional impairments lead to unnecessary hospitalizations and institutionalization in nursing homes.

Formal psychological testing is the single most effective means of making subtle differential diagnoses between dementias and other cognitive impairments, on the one hand, and highly treatable and reversible conditions, such as depression, on the other hand. Nevertheless, the majority of older Americans who are simply not functioning well for whatever reason are summarily medicated or institutionalized by physicians with limited diagnostic training in this area and who more often than not fail to refer their patients for appropriate psychological evaluations.

SOMETIMES "TAKE TWO VALIUMS AND CALL ME LATER" ISN'T ENOUGH

The medical monopoly on care of the mental health needs of the elderly has tended to emphasize tranquilization and other forms of chemical behavior control rather than effective psychological interventions that promote rehabilitation and skill development. Although older persons represent only 13 percent of the general population, they receive 35 to 40 percent of the sedative-hypnotic medications prescribed. One recent study found that over 60% of residents in a nursing home were receiving psychotropic medications in the **absence** of a diagnosable mental disorder.

As a result of the many often unpredictable and poorly monitored side effects of such medications, the quality of life of many of the elderly suffers dramatically and the medical management of the elderly has often become unnecessarily complex and expensive. The elderly have 250,000 hospital admissions a year for adverse drug reactions.

HOW MUCH IS MINIMALLY ADEQUATE CARE WORTH?

The Congressional Budget Office has estimated that inclusion of psychologists will cost 25 million dollars over the next five years, only about 0.04% of the total Medicare Part B expenditures. According to their report, "The effect of this act, if passed, would be to improve access of Medicare beneficiaries to outpatient mental health services...". Even this estimate is sure to be higher than the real cost inasmuch as the provision of appropriate psychological services and corresponding reduction in the use of tranquilizing and sedative medications can be shown to be effective in substantially reducing hospitalization and other major medical expenses.

Indeed, the accounting firm, Peat, Marwick, Mitchell & Company, using the highly conservative assumption that psychological services will reduce medical costs by only 5% (1/3 to 1/4 the actual effect indicated by the scientific literature) projects the annual cost of psychologists' inclusion by 1994 at only $11 million (as compared to C.B.O.'s estimate of $30 million). Using the more realistic but still conservative assumption of a 10% offset of medical costs, the inclusion of psychologists as independent health service providers would actually **reduce** Medicare Part B costs.

AN EASY WAY TO REDUCE "PART A"

Moreover, these projections do not even take into account th inevitable reduction in Medicare Part A costs by shifting utilization away from expensive psychiatric hospitalizations Psychologists in Michigan, as in most states, have no hospital privileges and thus no incentive to contribute to unnecessary and extremely costly psychiatric hospitalization when outpatient treatment would be equally or more effective

Psychiatrists, on the other hand, are commonly threatened with losing their hospital privileges if they do not maintai a certain rate of inpatient psychiatric admissions. In othe words, they are constantly under pressure to admit their Medicare patients to psychiatric wards, where Medicare inpatient benefits can become a major profit center for the institution.

According to one recent study, a psychiatrist will need **120** hospital days to care for 1000 people in a year. By contrast, the figures of American Biodyne, which uses only fully licensed, doctoral level psychologists in its treatme programs, averages between **5** and **15** days per 1000 people pe year. Quality is not sacrificed for cost because Biodyne's treatment emphasizes intensive outpatient care.

WHO ELSE SUPPORTS THIS LEGISLATION?

Senate Bill 100 is vigorously supported by a large contingent of senior citizens groups as well as those public agencies entrusted with their care. These groups include, among others, the National Association of Area Agencies on Aging, the National Council of Senior Citizens, the National Association of State Mental Health Program Directors, and the National Hispanic Council on Aging.

"WAREHOUSING" THE ELDERLY--A NATIONAL DISGRACE

The frequency of inpatient psychiatric hospitalization of older Americans who are not mentally ill, but merely depressed, lonely, unskilled, and unwanted, is a national disgrace. The majority of these unfortunate individuals receive little or no treatment while inpatients, except medication, which when combined with the isolation from their daily routines, often adds to their confusion and helplessness and complicates their medical picture.

These same individuals, offered comprehensive outpatient rehabilitation by a psychologist, including training in cognitive and self-care skills as well as emotional support, can receive vastly superior results at a fraction of the cost. The passage of Senate Bill 116, sponsored by Senator Inouye, will make this alternative far more accessible to the nation's elderly.

S. 116 allows for licensed, doctoral-level psychologists to provide comprehensive outpatient rehabilitation services (something psychologists have both better training in and generally more incentive to provide than their medical colleagues). This bill is likely to reduce utilization of more expensive hospitalization and to provide broader access among the disabled elderly to providers in their vicinity.

We urge you and the members of the Subcommittee to support Senate Bills 100 and 116.

Respectfully submitted,

Robert Erard

Robert E. Erard, Ph.D.
Member, Michigan
Psychological Association--
Clinical Division, Insurance
Committee

Merton Shill

Merton Shill, Ph.D.
Chairman, Michigan
Psychological Association--
Clinical Division, Insurance
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Michigan Society Of Internal Medicine

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06/28/89

Honorable Donald W.Riegle, Jr.
United States Senate
Washington, D.C 20510

Dear Senator Riegle:

The Michigan Society of Internal Medicine joins you in your concern for the 37,000,000 without health insurance, and are pleased that a Michigan Senator is taking a leading role in bringing attention to this need.

However, let us point out that more government commitment to paying health costs, brings greater government debt. Ultimately, you will need to include in the expense of national health care programs the cost of their administration. In addition, there will be pressures for more benefits by voters who won´t be paying for what they want.

In short, an expanded national health care coverage will clash with the philosophy and function of Gramm-Rudman.

In addition, physicians experience with government controlled health program means uniformity of benefits and rigidity of administration; no room remains for physician initiative or innovation in patient care. The 37,000,000 Americans may gain coverage by national health care legislation. At the same time they well may lose their opportunity to find doctors with services most suited for their concerns.

Physicians are responsive to the needs of the uninsured. What we are likely to oppose is having our activities driven by the laws of Congress, augmented by regulations from HCFA, and enforced by policies of the Attorney-General´s office.

Instead, we want to work with programs developed by individual insurance companies, refined by cost conscious employers, and implemented by informed employees.

It is out of the tulmult of the market place, rather then the committees of Congress, that health plans will evolve which will balance personal needs with fiscal realities.

Yours,

Joseph J. Weiss MD
President Mich Society Internal Medicine

JAMES J. BLANCHARD, Governor

STATE OF MICHIGAN
DEPARTMENT OF LABOR
MICHIGAN EMPLOYMENT SECURITY COMMISSION
RICHARD SIMMONS, JR., Director
7310 WOODWARD AVE., DETROIT, MICHIGAN 48202

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Honorable Donald Reigle, Jr.
United States Senator

Senator Reigle,

Thank you for inviting me to attend the Senate hearing on health. I would like to contribute comments on this subject:

I feel that establishing some means of providing continued health care for laid-off workers is crucial to the health and welfare of their families.

One of the most asked questions when filing for long term unemployment insurance (no call back date) is "How can I get medical or hospitalization insurance?"

An optional contributory plan would work well. Optional, because each U.I. recipient has different circumstances. Some have medical coverage even if unemployed, i.e. spouse is also working and has coverage etc. Contributory, because people should not only have the option of wanting coverage, but should have some of the responsibility of financing the program.

Because the amount each individual may receive as a weekly benefit rate varies greatly (in Michigan it varies from a low of $59.00 to the high of $263.00), the weekly contributory amount should be a percentage, not a stated flat amount. In this manner each individual would be contributing a equitable amount.

This program should last for the duration of the workers U.I. benefits. After that period of time other social programs would have to take over, if available. In other words, this would not be a continuing program, but a supplement to the Unemployment Insurance coverage.

Don Previch

Donald Previch
Manager
Livonia Branch Office
28003 West Eight Mile Road

MICHIGAN STATE UNIVERSITY

COLLEGE OF NURSING

EAST LANSING • MICHIGAN • 48824-1317

June 23, 1989

The Honorable Donald W. Riegle, Jr.
United States Senate
705 Washington Square Building
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

Thank you for providing the opportunity for individuals to express their concerns about health care for the uninsured. Unfortunately, I will be out of the state on June 28th and will be unable to attend the hearing in Southfield. Therefore, I am providing the following written comments.

If we are to approach success in providing health care for all citizens, serious attention must be given to: a.) how money flows, b.) purposes for which money is spent, and c.) who is supported to provide care. Currently, our focus is on disease and its cure by physicians. This is the most expensive approach to health care. We must see that disease prevention and health promotion become the foci of attention and that health professionals who are particularly prepared in these areas are supported. Communities also need to be supported that show a plan for self-care, disease prevention, and health promotion.

Further, it is well documented that nurses provide cost effective health care. However, nurses are blocked from being paid directly for services provided. Needed cost effective services cannot be made available. Our college, similar to other colleges of nursing, has great difficulty finding support for nursing clinics for groups such as women, minorities, low income families, and the elderly. The lack of availability of third party reimbursement for nurses is a central problem. Not only are health services unavailable to the poor, but also educational opportunities for students and research opportunities for faculty and students are lost.

I am aware this letter sounds self-serving for the profession of nursing, however, the recent report by the Secretary's Commission on Nursing from the Department of Health and Human Services, as well as other reports, strongly support these views.

It is time for a fresh look at the health care needs of the nation and new ways of meeting these needs. We can no longer afford to just reshape the way cure of diseases is approached by physicians. Our more basic problems must be faced.

Thank you again for an opportunity to express my opinions.

Sincerely,

Gladys A. Courtney

Gladys A. Courtney, R.N., Ph.D.
Dean and Professor

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1025 James Street
White Cloud, Michigan 49349

JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
C. PATRICK BABCOCK, Director

White Cloud, MI 49349

June 27, 1989

The Honorable Donald W. Riegle, Jr.
United States Senator
Suite 716, Federal Building
110 Michigan, N.W.
Grand Rapids, Michigan 49503

Dear Senator Riegle:

I am submitting the following written testimony regarding the problems of access to health care for uninsured individuals.

The low income, single, adults age 21 through 64 are the primary segment of our population that are most apt to be affected by inadequate health care due to being uninsured. These individuals frequently fall through the cracks in the Medical Assistance (MA) programs since they generally don't qualify for MA unless they have a condition which disables them for a period of twelve months or more. These individuals have medical needs which are going untreated since they don't qualify for MA and they cannot afford to purchase the needed medical services. If left untreated, some conditions could result in permanent disability.

General Assistance medical programs provide outpatient assistance to these individuals, provided that their assets are under $250.00.

County Hospitalization programs vary throughout the State, but generally speaking, they are quite restrictive since counties have limited dollars available to cover these expenses. Repay agreements are required, and amount is frequently limited to a maximum dollar amount (such as $2,000). Many times, if the applicant is capable of becoming gainfully employed in the future, the application is denied since it is expected that the client should work out a repay agreement with the hospital.

Due to the above mentioned concerns, it is suggested that consideration be given to simplifying the MA spend-down policy by establishing a one month spend down and increasing GA asset limit to $1,000 for GA-Medical only so the working poor don't have to become totally destitute before they can access health care. County Hospitalization programs should be reviewed to insure some minimal medical treatment.

Thank you for giving consideration to the health care of the uninsured since so many individuals are affected by this issue.

Sincerely,

Sharon Christensen

Sharon Christensen
Acting Director
Newaygo County
Department of Social Services

SC/cmp

MSMS PRESS UPDATE

For Immediate Release
Wednesday, May 4

Contact: David K. Fox
Chief, Media Relations

SIXTY PERCENT OF RESIDENT-PHYSICIANS PLAN TO LEAVE MICHIGAN

EAST LANSING - Six of every 10 physicians currently in a residency training program plan to leave Michigan once their education is completed, according to a survey released today by the Michigan State Medical Society (MSMS).

Another 10 percent are uncertain if they will stay in Michigan. Only 30 percent of the physicians-in-training plan to stay.

High costs of liability insurance and the malpractice climate in Michigan are the two top reasons these young physicians plan leave, the survey found.

"If we don't start to take care of this problem now, Michigan patients will begin to lose access to physicians, particularly those in the high-risk specialties," said Fred W. Bryant, MD, of Royal Oak, president of the 11,000-member MSMS.

In specialty areas, 63 percent of the obstetricians/gynecologists; 79 percent of the emergency room physicians; and 92 percent of the orthopaedic surgeons plan to leave Michigan at the end of their residency programs.

Michigan, at 1.9 physicians per 1,000 people, already is below the national average of 2.2 physicians per 1,000 people, said MSMS Manager of Medical Economics, Thomas White, who conducted the survey.

Residency programs are two to six years of specialized training in a hospital setting following completion of medical school.

Results have been tabulated from 318 responses to a survey mailed in March to 76 state residency programs. There are currently an estimated 2,000 physicians in residency training in Michigan.

Only in family practice do a majority of residents, 62 percent, plan to stay in Michigan.

The number of residents who plan to leave Michigan correlates directly to the cost of medical liability (malpractice) insurance they would be required to pay and the frequency of lawsuits against the specialty.

-more-

While a colleague in an Indiana city pays $14,408 a year for a $100,000 policy, an obstetrician/gynecologist in Detroit would pay $51,952. A Michigan obstetrician, however, seldom buys a policy as low as $100,000; the standard in Michigan is $200,000 coverage for which a Detroit obstetrician pays approximately $68,274 per year.

The MSMS survey results are similar to, but higher than, earlier surveys of residents conducted by other health care organizations.

In the years 1984-86, surveys conducted by the Michigan Council on Graduate Medical Education showed 43 to 44 percent of physician residents planned to leave Michigan. In 1987, a survey of residents by the Michigan Health Council showed 56 percent plan to leave.

The increase in the number of residents leaving reflects the increase in lawsuits filed against Michigan doctors over the past few years. In 1980, the two largest medical liability insurance companies reported a total of 925 suits against doctors. In 1986, they reported 2,345.

The Michigan State Medical Society is urging Gov. James J. Blanchard to appoint a special task force to study more equitable alternatives to the current court system for settling medical liability claims as recommended by his medical liability fact-finder, Robben Fleming, the former, and currently interim, president at the University of Michigan.

-30-

For radio actualities, complete survey questions and raw numbers, please call David Fox at MSMS, 517-337-1351.

RESULTS OF MSMS SURVEY OF RESIDENT PHYSICIAN INTENTIONS ABOUT PRACTICING IN MICHIGAN

In March 1988 the Michigan State Medical Society sent survey questionnaires to 76 residency programs in Michigan for distribution to resident physicians in each program. The purpose of the survey is to ascertain resident's attitudes and intentions toward establishing practices in Michigan upon completion of their training. Thus far, MSMS has received responses from residents in 58 of the 76 programs, with a total of 318 individual responses.

Following are responses to select questions from the survey:

Q: Do you intend to practice in Michigan?

Yes 95; No 189; Maybe 34

Q: Before beginning your residency program had you planned to practice in Michigan?

Yes 128; No 165; Maybe 25

Q: If you are planning to leave Michigan, what factors influenced your decision? (Numbers in each column represent the frequency of times the item was checked as a response.)

	Major Factor	Minor Factor	Not Considered
Cost of Living (in Mich.)	10	79	129
Family Obligations	65	71	82
Overall Practice Expenses	53	79	83
Peer Review Structures	13	73	118
Malpractice Climate	172	34	26
Liability Insurance Costs	156	42	31

A breakdown of results by specialties responding is:

Specialty	# Planning on practicing in Michigan	# Planning on leaving Michigan after residency
Anesthesiology	1	6
Emergency Medicine	3	11
Family Practice	31	19
General Surgery	2	6
Internal Medicine	17	22
OB/GYN	22	37
Orthopedic Surgery	5	57
Oncology	0	3
Pediatrics	4	5

MSMS NEWS OF MEDICINE

For Immediate Release
Wednesday, May 11

Contact: David K. Fox
Chief, Media Relations

MICHIGAN PHYSICIANS' INSURANCE RATES HIGHEST IN GREAT LAKES AREA

EAST LANSING - Michigan physicians must pay three to five times as much for medical liability insurance as their colleagues across the Indiana state line, according to a study released today by the Michigan State Medical Society (MSMS).

Medical liability insurance rates in Michigan are higher than in any surrounding Great Lakes state, the study further showed.

Neurosurgeons in the Detroit area pay in excess of $80,000 each year for a $200,000 policy, the study found, while many outstate obstetricians/gynecologists have stopped delivering babies because their insurance costs cannot be covered by the number of deliveries performed.

For $100,000 coverage, an obstetrician in a Michigan metropolitan area pays $51,952. In Indianapolis, Indiana, that same obstetrician would pay $14,408 for $100,000 coverage; in Columbus, Ohio, $18,570; and in Chicago, Illinois, $34,255. In Milwaukee, Wisconsin, an obstetrician pays $31,746 for a $300,000 policy. A lower policy amount is not available there.

Most Michigan obstetricians carry a minimum of $200,000 coverage, which costs about $68,274 in a metropolitan area.

Based on a 40-hour week, an obstetrician must earn $34 an hour just to pay for insurance. Obstetricians' insurance rates have increased 406 percent in the past four years.

"It's no wonder that obstetricians graduating from our medical schools and completing residency programs are leaving Michigan," said MSMS president Fred W. Bryant, MD, "if they can simply cross the Indiana border and pay a third of what they would pay in Michigan for medical liability insurance."

"Our medical school graduates are a priceless resource," Dr. Bryant said. "We need to do something to keep our energetic and enthusiastic young physicians in Michigan."

Ever-increasing numbers of lawsuits, increasing amounts of jury awards and resulting high insurance rates will continue to drive obstetricians from Michigan, according to MSMS Manager of Medical Economics, Thomas White, who conducted the study.

-more-

DEPARTMENT OF COMMUNICATIONS AND PROFESSIONAL RELATIONS
MICHIGAN STATE MEDICAL SOCIETY, P.O. BOX 950, EAST LANSING, MI 48826-0950
517 337-1351

Other Michigan physicians pay similarly high rates, he said, the amount depending on the specialty.

Malpractice insurance rates for Michigan and adjacent states for selected specialties in metropolitan areas are listed below, based on $100,000 occurrence insurance policies. Illinois figures are based on a mature claims-made policy, which is the closest comparison to an occurrence policy.

General Practitioner,
with no surgery
Indiana - $1,695
Ohio - $2,948
Illinois - $7,060
Michigan - $8,033

General Practitioner,
with minor surgery
Indiana - $4,068
Ohio - $9,256
Illinois - $10,761
Michigan - $22,642

General Surgeon
Indiana - $8,888
Ohio - $15,328
Illinois - $23,126
Michigan - $30,187

Obstetrician/gynecologist
Indiana - $14,408
Ohio - $18,570
Illinois - $34,255
Michigan - $51,952

The Indiana figures include a 125 percent surcharge of base rates used to finance a patient compensation fund which places a cap on liability awards.

The lowest policy amount a Wisconsin physician may buy is $300,000, for which he or she pays about half what a Michigan physician pays for a $100,000 policy. In the specialty areas above, a physician in Wisconsin pays $4,233; $6,350; $19,048; and $31,746, respectively.

The Michigan State Medical Society, the professional association of 11,000 medical doctors, is urging Gov. James J. Blanchard to appoint a special task force to study the state's medical liability situation and develop alternatives to the tort system for settling medical liability claims.

-30-

YEARLY MALPRACTICE RATES
FOR MICHIGAN & ADJACENT STATES
FOR SELECTED SPECIALTIES
$100,000/300,000 Occurrence Policies*

	METRO AREAS			
	MICHIGAN	INDIANA	OHIO	ILLINOIS
GP - no Surg.	$8,033	$1,695	$2,948	$7,060
GP - w/ Surg.	$22,642	$4,068	$9,256	$10,761
General Surg.	$30,187	$8,888	$15,328	$23,126
OB/GYN	$51,952	$14,408	$18,570	$34,255

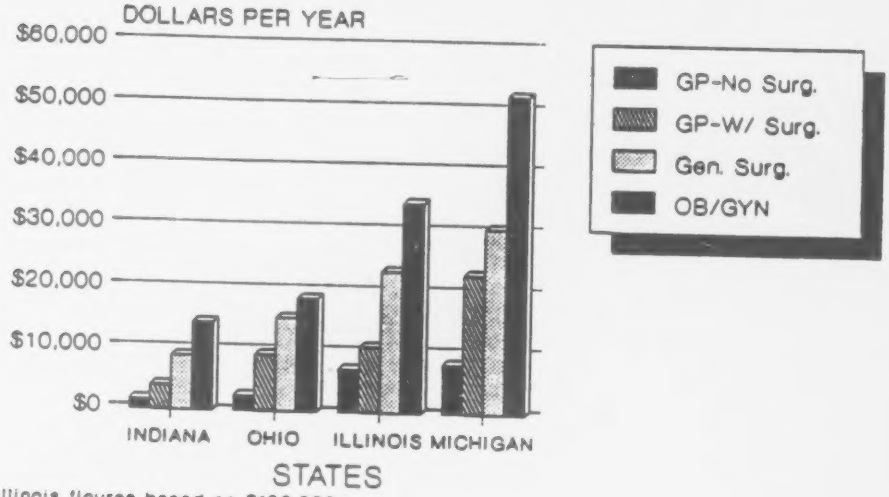
	NON-METRO AREAS			
	MICHIGAN	INDIANA	OHIO	ILLINOIS
GP - no Surg.	$4,820	$1,334	$2,948	$5,823
GP - w/ Surg.	$13,585	$3,201	$9,256	$8,787
General Surg.	$18,490	$7,003	$15,328	$18,680
OB/GYN	$31,172	$11,340	$18,570	$27,581

* Illinois figures based on $100,000/300,000 mature Claims Made Policy.

Indiana figures include a 125% premium surcharge on base rates, allowing physicians to participate in a Patient Compensation Fund which places a cap on liability awards.

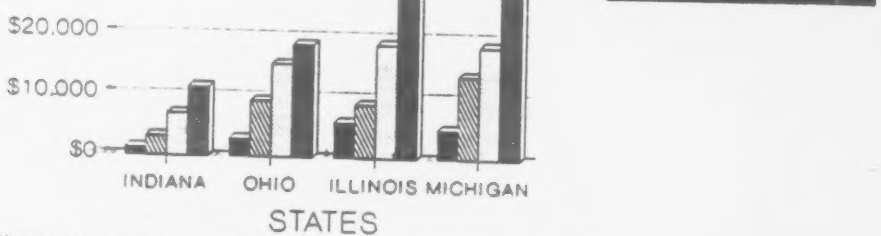
PRODUCED BY: MICHIGAN STATE MEDICAL SOCIETY
SECTION ON MEDICAL ECONOMICS

ANNUAL MALPRACTICE RATES
FOR MI & NEARBY STATES' METRO AREAS
$100,000/300,000 OCCURRENCE POLICIES*



* Illinois figures based on $100,000/300,000 Claims Made Policies. Indiana figures include a 125% surcharge.

NON-METRO AREAS



* Illinois figures based on $100,000/300,000 Claims Made Policies. Indiana figures include a 125% surcharge.

State's environment affects residents' location decisions

by Colleen Elliott

Malpractice. Although the Michigan legislature passed some tort reform measures in 1986 to temper soaring malpractice costs and the high liability nature of the state, in 1988 the malpractice climate in the state is no better. Newspapers report established physicians leaving their practices to move to other locations where the malpractice cost is a fraction of what they pay in Michigan. But the exodus of physicians is not limited to those already in their own practices. More and more residents are choosing to leave the state once they finish their training programs.

Elizabeth Sofian, MD, specializing in gastroenterology, and Steve Conlan, MD, an orthopedic surgeon, are two of those residents. This month the couple, graduates of the Wayne State University Medical School and residency program, will be moving to Denver to join Permanente Medical Group, a group of physicians who serve the Kaiser Health Plan.

"Malpractice is not strictly the one reason we said no to staying in Michigan. A lot of aspects of the malpractice problem cause turmoil in practices we see and work with," Conlan says. "You hear about the problems and what's going on. So many of the senior staff were talking about retiring early, getting out. I made the decision not to even look in Michigan."

Growing numbers of residents decide to leave

And they're not alone. A recent study of medical residents conducted by the Michigan State Medical Society found that six out of 10 physicians in Michigan residency programs plan to leave the state upon completing their education. And another 10 percent are uncertain whether they will stay. Especially hard hit are some of the specialty areas. The study found that 63 percent of the obstetricians/gynecologists, 79 percent of emergency room physicians, and 92 percent of orthopedic surgeons plan to leave the state. Only in the area of family practice do a majority of residents, 62 percent, plan to stay in Michigan.

"In the five years that I've been a resident, only one among the orthopedic surgeons has stayed," Conlan said. That means that only one in 20 orthopedic surgeons in Conlan's program stayed in Michigan.

"When I did my internal medicine residency, maybe 75 percent of the 50 residents have left Michigan," Sofian says. "Some went on to do other fellowships, but they were very eager to leave Michigan. Nobody wanted to stay here."

The two top reasons for these residents leaving the state? High costs of liability insurance and the malpractice climate.

Michigan's medical malpractice costs have skyrocketed. Today Michigan physicians pay up to five times more for medical liability insurance than doctors in neighboring states. The same insurance policy for an obstetrician in metropolitan Michigan costs $51,952, while the same doctor would pay $14,408 in Indianapolis. In Chicago he would pay $34,255, while in Columbus he would pay $18,570. Michigan's rates are even higher in the non-high risk categories. For example, a general practitioner in Michigan would pay $8,033 for insurance. For comparable coverage in Ohio that physician would pay $2,948 and in Indiana $1,695.

Number of lawsuits increasing

The increase in the number of residents leaving also reflected the increase in lawsuits filed against Michigan doctors over the past few years. In 1980, the two largest medical liability insurance companies reported a total of 925 suits against doctors. In 1986, they reported 2,345.

"Every day you hear of unbelievable lawsuits," says Conlan. "There's a need for tort reform, including control of the malpractice problem, because I think the field of medicine, which I care very deeply about, is going to suffer because of it in the long run.

"The ultimate problem is that malpractice insurance in Michigan is essentially no fault," Conlan says. "All the good doctors are paying for bad doctors, shifting the fault to the group. If you've been a good doctor with no problems for 10 years your rates don't go down."

He cited the tendency of juries to sympathize with the patient in court cases, especially in Wayne County, as a reason for the high rates. "It's just like car insurance. You can live in Royal Oak but you get charged on the Detroit rate. Most practices through Michigan are higher than in Ohio or Wisconsin strictly because of the influence of Detroit and Wayne County throughout the state."

Medicine offers a special challenge

Because medicine is such a personal service, it offers a unique situation for lawsuits. Physicians seem to be sued as much for their bedside manner as for their medical ability.

"So many times you see doctors getting sued for personality problems," Sofian says. "Not that they didn't do a good job. The patient has taken a dislike to the doctor or maybe the doctor has been abrupt and he ends up getting sued." She said it also works the other way. "You can see some legitimate malpractice and the patient wouldn't dream of suing the doctor because they love him so much."

In addition, Conlan says that higher expectations lead to malpractice problems. He says that medicine here has become so good that people expect perfection and may sue if they don't get it. As an orthopedic surgeon, he said that he would consider a surgery a success if it gave the patient use of an arm, for example, even though there might be a slight bend in the bone. But the patient, used to seeing a straight arm, may sue for malpractice.

photo by Colleen Elliott

> "The ultimate problem is that malpractice insurance in Michigan is essentially no fault. All the good doctors are paying for bad doctors, shifting the fault to the group."

Climate leads to defensive medicine

According to Conlan, "A tremendous amount of bad defensive medicine is going to be run and a tremendous amount of dollars are going to be lost in redundant needless tests."

In fact, the American Medical Association estimates that for each dollar of malpractice risk, $3.50 is spent on defensive medicine. And a Michigan State Medical Society study found that 80 percent of physicians in the state said they order some tests simply because of malpractice risks.

"It's to the point now where we're trained in practicing defensive medicine. Every time we do something, our staff people say to make sure you document this or make sure you document that because our malpractice rates are going up and we might be sued," Sofian says. "It's disturbing."

Doctors need to do their part

Conlan says although there are many problems facing Michigan physicians, there are many things the medical profession must do before the problems are solved.

"I see a lot of articles where a doctor or group of doctors is talking and all they're doing is saying how poor life is and how they can't survive. We're not like that. Malpractice is a big problem in the state of Michigan, but it's not the only problem. And I think there are a lot of problems on the doctors' side of it.

"Doctors for far too long have been without restraints, have poorly policed themselves. Much of the problem is not so much by their doing, but their lack of doing. And that has helped feed a lot of people's negative attitudes about medicine and doctors."

He says that throughout their residencies both have seen malpractice. "As a referral center, we see cases sent in and we can't believe how it was treated elsewhere. I've seen mistakes and problems down here. Yet, it's not encouraged to turn in fellow doctors and report them. Even good people make mistakes."

He says doctors should also be pushing for recertification or mandatory continuing education. "Most doctors don't want to have mandatory continuing education. But, if you're not willing to keep up with the field of medicine, problems may occur.

"I'm not saying that all lawsuits are right. But I also don't agree with a lot of the doctors who want government off their backs, who want protection from lawsuits, and then don't want to keep up their education, don't want to have to answer to anybody."

Both Conlan and Sofian predicted that more residents will continue to leave the state and that the malpractice climate will not improve in the near future. That could spell trouble for Michigan residents when trying to find a physician, especially those practicing in high-risk areas like obstetrics, neurosurgery, and orthopedic surgery. Currently, Michigan is already below the national average of 2.2 physicians per 1,000 residents. That percentage is likely to decrease.

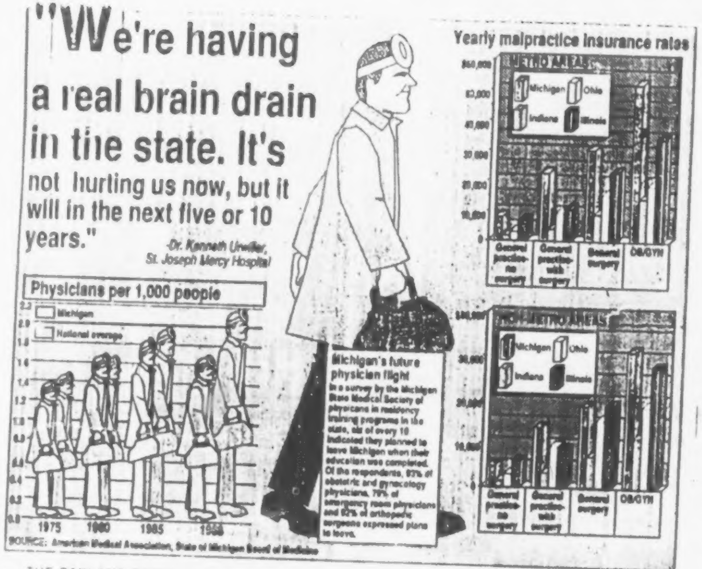
"I think there will continue to be a mass exodus of physicians," says Sofian. "I think family ties tend to keep people in Michigan more than anything—that they've lived here all their lives. But you're also going to see people like me who have lived here all their lives and are leaving."

"The environment is not ideal by any means," Conlan says. "When I came to Wayne State I had planned on staying in the state. I had always thought that since the people in Michigan support the medical schools and paid for much of my education that it would only be fair to stay and work. Michigan is certainly a nice state and it's my home. But now my plans have had to change."

photo by Colleen Elliott

"When I did my internal medical residency, maybe 75 percent of the 50 residents have left Michigan . . . they were very eager to leave Michigan. Nobody wanted to stay here."

Colleen Elliott is staff associate, Public Affairs and Communications, at the MHA



"We're having a real brain drain in the state. It's not hurting us now, but it will in the next five or 10 years."

-Dr. Kenneth Urwiller, St. Joseph Mercy Hospital

Michigan's future physician flight

In a survey by the Michigan State Medical Society of physicians in residency training programs in the state, six of every 10 indicated they planned to leave Michigan when their education was completed. Of the respondents, 83% of obstetric and gynecology physicians, 79% of emergency room physicians and 92% of orthopedic surgeons expressed plans to leave.

SOURCE: American Medical Association, State of Michigan Board of Medicine

The Oakland Press/MARK RADEMACHER

THE OAKLAND PRESS Sunday, October 9, 1988

Insurance pushes doctors away

State trains physicians for others

By DIANA DILLABER
Of The Oakland Press

In five years, it may be extremely difficult to find a doctor in Michigan. In 10 years, it may be almost impossible.

"We're having a real brain drain in the state," said Dr. Kenneth Urwiller, vice president of medical services at St. Joseph Mercy Hospital in Pontiac. "It's not hurting us now, but it will in the next five or 10 years."

Many new doctors complete their education and training in Michigan schools and hospitals, then leave the state to practice where there are fewer malpractice suits, lower court settlements and where insurance rates are not as high, local and state medical officials said.

In the first six months of this year, about $37 million has been paid out by Michigan Physicans Mutual Liability Co., the state's largest medical insurer, said company spokesman Brian Hodge.

A survey of doctors in residency programs across the state, taken this spring, indicated six of every 10 plan to leave Michigan once their education is completed, said Dave Fox, spokesman for the Michigan State Medical Society.

The survey indicated 83 percent of obstetrics and gynocology physicians, 79 percent of emergency room physicians and 92 percent of orthopedic surgeons plan to leave.

Already the number of doctors per person is lower in Michigan than nationwide.

There are currently 17,000 doctors in the state or 1.9 physicians for every 1,000 persons, said Ted White, a spokesman for the medical society. The national average is 2.2 physicians per 1,000 persons.

White said there are 2,500 doctors now in residency programs and 1,500 plan to leave.

Hodge said society already is suffering because of physicians leaving the state and because of physicians' reluctance to treat certain types of cases because of the rising cost of malpractice insurance.

Malpractice is the No. 1 legal issue in the medical field, said Ronald J. Schurra, executive vice president of St. Joseph Mercy Hospital.

White said, "Michigan is among the highest nationally" in malpractice insurance costs. He said the costs are about the same as south Florida.

(Continued on A-10)

Insurance rates force physicians out of state

(Continued from A-1)

which has received national attention for skyrocketing malpractice insurance costs.

Insurance rates are especially costly in such high-risk medical fields as obstetrics-gynocology, neurosurgery and orthopedic surgery.

"These are the three high-risk areas we hear the most about as far as the number of lawsuits and rising insurance costs," said Terry Vanderveen, a Michigan State Medical Society spokesman.

For example, Vanderveen said a neurosurgeon in Michigan is required to pay $100,000 a year for $200,000 insurance coverage under rate increases that took effect in June.

A general practitioner who performs no surgery pays around $8,900 a year in insurance premiums. If that same doctor did minor surgery, Fox said the cost of insurance would go up to $24,000.

Among doctors in Michigan, Indiana, Ohio and Illinois, Michigan physicians pay the most for insurance coverage.

For example, the average obstetrician pays about $56,000 annually for insurance in Michigan while the average insurance bill in Indiana is $14,408.

"When you hear that in Ohio the cost is one-half what premiums are here, it's no wonder we are losing physicians," Urwiller said.

When older doctors retire, the shortage of doctors will increase, said Dr. Frederick Minkow, an orthopedic surgeon at St. Joseph Mercy Hospital and chairman of the Michigan State Medical Society Committee on State Legislation and Regulations.

Minkow, Schurra and Hodge presented their insurance concerns to several lawmakers and challenging candidates at a recent meeting of the Legislative Advisory Council.

[illegible] Crittenton, Beaumont and Pontiac Osteopathic hospitals also are represented on the council.

Since 1982, the average pay out in a court action has been between $48,000 and $80,000, said Hodge, spokesman for Michigan Physicans Mutual Liability Co., a non-profit insurer that is owned by its members.

The total payout on claims and legal expenses in 1987 was about $17.3 million. In 1977, the non-profit company paid out $55,000. Payouts hit $1 million in 1980 and the amount grew to more than $12 million in 1982.

"To feel sympathetic about a bad outcome is understandable, but to expect physicians to pay for it is ill advised," Hodge said.

"Obviously, not every individual can be treated to a perfect result. To hold physicians or hospitals responsible can be very bizarre, particularly when they have made a career of helping people."

Schurra encouraged state legislators to change the statute of limitations and set a reasonable time limit within which a lawsuit must be filed. Currently, malpractice lawsuits can be filed years after an incident.

Schurra also asked legislators to set a cap on what can be claimed or collected in a court action.

"We are a major provider," Schurra said of St. Joseph Mercy Hospital. "Individuals attack us because we have deep pockets. When that happens, pockets have a way of getting shallow."

MEDICAL LIABILITY INSURANCE
AND
FAMILY PRACTICE

Michigan State Medical Society
Michigan Academy of Family Physicians

Purpose

The purpose of this study is to determine the magnitude of the medical liability insurance problem among members of the Michigan Academy of Family Physicians (MAFP). In addition the study determines the members' perceptions of the problem, the changes in their practice, and their attitudes. This study is a replication of a similar study done in 1985.

Methodology

A self-administered mail questionnaire was sent to all 973 members of MAFP. A cover letter describing the purpose of the study was sent with the questionnaire. The cover letter was on Michigan State Medical Society stationery and was co-signed by the president of the society and the president of MAFP.

Within two weeks 350 questionnaires were returned, providing an effective return rate of 36%. If the returned questionnaires are assumed to be a random representation of the entire membership of MAFP, then the largest range of error would be within 3% at a 90% level of confidence.

The questionnaires were edited and coded, and then tabulated by computer. Questions were tabulated omitting individual questions that were not answered. The base for computation of percentages, then, changes for each question depending upon the number of valid responses.

Characteristics of the Sample

The average member of MAFP is 44.49 years old and has completed medical training an average of 15.53 years ago. He or she has been a certified member of MAFP for an average of 8.57 years. About 9 out of 10 are males, and over half practice in rural areas and small towns, as shown in Table 1.

About 2 out of 5 practice in a single practice, with about 1 out of 3 in a family group practice. The average size of the group reported is 4.7. The average office is open 49.39 weeks per year, with an average number of patient visits per week of 118.69. This translates to over 5,800 patient visits per year per MAFP member.

Just less than half, 45.7%, report delivering no babies. Among those that reported delivering babies, the average number is 37.6 in 1986. The highest number reported is 515, but this is not a typical case. Overall, including those that did not deliver any babies, the average number of babies delivered per MAFP member in 1986 is 20.1.

The majority of payments received by MAFP members come from Blue Cross Blue Shield and commercial insurance companies as shown in Table 2. Overall payments from an H.M.O. appear to be small because only 16% of MAFP members report receiving any. Of those who do receive payments from an H.M.O., the proportion increases to 25% of their payments.

Table 1. Characteristics of the Sample.

Gender

	Frequency	Percent
Male	306	87.9
Female	42	12.1
TOTAL	348	100.0

Type of practice

	Frequency	Percent
Single practice	146	41.7
Family Group	116	33.1
Mixed Group	29	8.3
H.M.O.	4	1.1
Hospital based	5	5.1
Academic	20	5.7
Retired	17	4.9
TOTAL	350	100.0

Type of community

	Frequency	Percent
Rural	84	24.3
Small town	99	28.6
Detroit	56	16.2
Grand Rapids	23	6.6
Kalamazoo	19	5.5
Flint	14	4.0
Lansing	25	7.2
Saginaw	7	2.0
City not specified	19	5.5
TOTAL	346	100.0

Table 2. Distribution of Payments by Source.

	Percent
Commercial insurance	26.9
Blue Cross Blue Shield	26.6
Medicaid	23.9
General assistance	2.7
Direct from patient	11.5
H.M.O.	8.4
TOTAL	100.0

Table 3. Location by Sample Characteristics.

Percentages by Column

	Years certified by MAFP			
	1 to 5	6 to 10	11+	Total
Rural	32.0	20.6	22.5	25.0
Small towns	23.7	36.4	22.5	28.2
Detroit	19.6	18.7	12.5	17.3
Other cities	24.7	24.3	42.5	29.6
Total	34.2	37.7	28.2	100.0

	Gender		
	Male	Female	
Rural	24.4	23.8	24.3
Small towns	28.7	28.6	28.7
Detroit	16.2	14.3	15.9
Other cities	30.7	33.3	31.0
Total	87.8	12.2	100.0

	Perform Surgery		
	Yes	No	
Rural	24.2	26.1	24.8
Small towns	29.5	28.6	29.1
Detroit	14.0	17.6	15.3
Other cities	32.4	27.7	30.7
Total	63.5	36.5	100.0

	Deliver Babies		
	Yes	No	
Rural	34.6	13.1	26.7
Small towns	34.6	24.3	30.8
Detroit	5.4	31.8	15.1
Other cities	25.4	30.8	27.4
Total	63.4	36.6	100.0

	Type of practice			
	Single	Group	Other	
Rural	30.3	22.1	14.3	24.3
Small towns	26.2	34.5	19.6	28.6
Detroit	13.1	17.2	21.4	16.2
Other cities	30.3	26.2	44.6	30.9
Total	41.9	41.9	16.2	100.0

Table 3 compares the proportion of various sample characteristics with different geographic locations. The percentages should add to 100 down the columns, except for the total row, which should add to 100 across the columns. The comparison is made between columns including the total column. The bottom row shows the relative importance of each column.

Table 3 shows that younger MAFP members are more likely to be located in rural areas, and that more experienced members are more likely to be located in cities other than Detroit. Also MAFP members located in rural areas and small towns are more likely to deliver babies than those in the cities.

Findings

The findings of the study are divided into three sections, the characteristics of the practice and planned changes, the experience with medical liability insurance, and related attitudes about obstetrical issues.

Delivery of Babies

Over one third of the reporting MAFP members said that they do not deliver in 1987 as shown in Table 4. This compares to 1 out of 5 who said they did not deliver babies in the 1985 study. A smaller proportion in the current study also said that they had changed their practice than in the previous study. Just over on third said they did not change the number of deliveries between the years. Of those that changed, approximately 3 out of 5 reported a decrease in the number of babies delivered. The average percent decrease reported was approximately 57%. The remaining 2 out of 5 who reported increases in the number of babies delivered had an average percent increase of nearly 43%. Overall the net percent change reported in the number of babies delivered was a decrease of 17%.

Table 4. Change in Practice.

	1985 from 1983		1987 from 1985	
	Frequency	Percent	Frequency	Percent
Don't deliver babies	66	21.9	108	36.7
No or same	127	42.1	107	36.4
Yes	109	36.1	79	26.8
TOTAL	302	100.0	294	100.0

When asked if any decision has been made in the last 5 years to either reduce the number or stop delivering babies altogether, over one third said they made no decision decision to change the number of babies they deliver, as shown in Table 5. This compares to well over half in the 1985 study. Over one third said they made a decision to reduce the number of deliveries, and about one fourth said they made a decision to stop delivering babies. The proportion saying that they have reduced the number of deliveries is considerably larger than in the 1985 study.

Table 6 shows that there already has been some decision making already in 1987. Table 7 shows that about 1 out of 4 are considering changing their practice. Only a relatively small proportion, 5.9%, are considering stopping delivering babies. Almost 1 out of 5 say they are considering increasing the number of deliveries.

Table 5. Decision to Change in last 5 years.

	1985		1987	
	Frequency	Percent	Frequency	Percent
No	176	57.7	108	36.7
Reduced deliveries	31	10.2	107	36.4
Stopped deliveries	98	32.2	79	26.8
TOTAL	305	100.0	283	100.0

Table 6. Already Made Change in 1987.

	Frequency	Percent
No	212	74.4
Increase volume	45	15.8
Decrease volume	3	1.1
Normal retirement	1	.3
Early retirement	2	.7
Stop Deliveries	19	6.7
Other	3	1.1
TOTAL	285	100.0

Table 7. Considering Future Change.

	Frequency	Percent
No	198	73.1
Increase volume	48	17.7
Decrease volume	7	2.6
Normal retirement	0	0.0
Early retirement	1	.4
Stop deliveries	16	5.9
Other	1	.4
TOTAL	271	100.0

By combining the responses to the questions that are reported in Tables 4 through 7, MAFP members can be placed in one of four categories, those who have already stopped delivering babies, those that plan to change the number of deliveries, and those who plan to continue delivering babies as in the past. As shown in Table 8, about one third say they have stopped delivering babies, with another one fourth saying that they plan to change. About 3 out of 5 are planning no change in the number of deliveries.

Table 8 shows some differences by the characteristics of the physicians. MAFP members who have been certified for less than 11, or those practicing in Detroit, years are more likely to have already stopped delivering babies.

Table 8. Change in Practice by Sample Characteristics.

	Years certified by MAFP			
	1-5	6-10	11+	Total
Stopped Already	25.9	28.7	50.8	33.5
Plan to Change	29.4	20.2	23.8	24.4
Plan No Change	44.7	51.1	25.4	42.1
Total	35.1	38.8	26.0	100.0

	Gender		
	Male	Female	
Stopped Already	38.4	29.0	37.4
Plan to Change	23.3	22.6	23.2
Plan No Change	38.4	48.4	39.4
Total	89.3	10.7	100.0

	Type of practice			
	Single	Group	Other	
Stopped Already	45.1	26.1	45.8	37.4
Plan to Change	23.0	28.6	10.4	23.2
Plan No Change	32.0	45.4	43.8	39.4
Total	42.2	41.2	16.6	100.0

	Type of community				
	Rural	Towns	Detroit	Cities	Total
Stopped Already	18.2	30.2	75.6	41.8	37.3
Plan to Change	40.3	39.5	24.4	46.8	39.4
Plan No Change	41.6	30.2		11.4	23.3
Total	26.8	30.0	15.7	27.5	100.0

	Claims filed		
	No	Yes	
Stopped Already	33.5	43.4	37.4
Plan to Change	22.2	24.8	23.2
Plan No Change	44.3	31.9	39.4
Total	60.9	39.1	100.0

Those in other forms of practice, such as academic medicine, hospital based, or H.M.O.s are also considerably more likely to be considering no change.

Assuming that professional fees could keep pace with inflation and other costs associated with the practice, about 2 out of 5 of the MAFP members said they would prefer to continue delivering babies as shown in Table 9. This proportion is down from the 1985 study.

Table 9. Prefer to Continue Obstetrics.

	1985		1987	
	Frequency	Percent	Frequency	Percent
Yes	171	57.8	129	43.7
No	91	30.7	129	43.7
Not sure	34	11.5	37	12.6
TOTAL	296	100.0	295	100.0

Surgery and Surgical Assistance

About 3 out of 5 of MAFP members say they have not made any decision to change the number of surgeries they have performed in the last 5 years. This proportion is almost the same as it was in the prior 1985 study.

Table 10. Decision to Change in last 5 years.

	1985		1987	
	Frequency	Percent	Frequency	Percent
No or same	193	66.1	208	63.4
Reduced surgery	46	15.8	59	18.0
Stopped surgery	53	18.2	61	18.6
TOTAL	292	100.0	328	100.0

Planned Changes in Practice

When asked how the increased costs of practice will be compensated, approximately half say they will pass them on to the patient, as shown in Table 11. This proportion is conservative because it includes all of those who did not answer the question at all in the base for the percentage. The next most frequently mentioned responses were avoiding high risk patients and temporarily absorbing the costs.

About 3 out of 4 say they have ordered more tests as a result of the current medical-legal environment, as shown in Table 12. About 2 out of 3 say they currently avoid high risk patients.

Table 11. Compensation for Increased Costs.

	Frequency	Percent
Temporarily absorb	136	40.0
Pass on to patient	188	55.3
Resign from fixed fee	25	7.4
Avoid high risk patients	140	41.2
TOTAL	340	

Table 12. Changed Method of Practice.

	Frequency	Percent
Ordered more tests	263	76.7
Avoid high risk	234	68.2
TOTAL	343	

Medical Liability Insurance

About 3 out of 5 of MAFP members report carrying $200,000-$600,000 coverage in their medical liability insurance as shown in Table 13. The other category in Table 13 includes higher coverage levels. The level of coverage also varies somewhat be the characteristics and location of the practice as shown in Table 14.

Table 13. Level of Coverage.

	Frequency	Percent
$100-300	88	25.6
$200-600	209	60.8
Going bare	6	1.7
Covered by hospital	18	5.2
Other	2	.6
TOTAL	344	100.0

Table 14. Level of Coverage by Sample Characteristics.

		Years certified by MAFP				
		1-5	6-10	11+	Total	
$100-300		26.3	28.4	33.3	29.1	
$200-600		73.8	71.6	66.7	70.9	
	Total	32.8	38.9	28.3	100.0	
		Delivering babies				
		Yes	No			
$100-300		23.2	41.6		29.6	
$200-600		76.8	58.4		70.4	
	Total	64.8	35.2		100.0	
		Perform Surgery				
		Yes	No			
$100-300		28.0	32.7		29.8	
$200-600		72.0	67.3		70.2	
	Total	62.1	37.9		100.0	
		Type of practice				
		Single	Group	Other		
$100-300		31.7	26.2	35.7	29.6	
$200-600		68.3	73.8	64.3	70.4	
	Total	46.8	43.8	9.4	100.0	
		Type of community				
		Rural	Towns	Detroit	Cities	Total
$100-300		25.6	23.5	53.5	25.8	29.2
$200-600		74.4	76.5	46.5	74.2	70.8
	Total	26.4	28.8	14.6	30.2	100.0
		Claims filed				
		No	Yes			
$100-300		28.2	31.9		29.6	
$200-600		71.8	68.1		70.4	
	Total	60.9	39.1		100.0	

Over 3 out of 4 of MAFP members reported an increase in the medical liability insurance premium in 1986, as shown in in Table 15. Only 1 reported a premium decrease. The average premium increase in 1986 was 55.8%. About 1 out of 6 said that they changed coverage in 1986. The average medical liability insurance premium in 1986 was reported as $9,830 per year. This is compared to the $4,500 reported in the previous study for 1984. This expense represents an estimated average of 11.6% of practice expenses.

Table 15. 1986 Premium Change.

	Frequency	Percent
Changed coverage		
No or same	39	14.2
Yes	23	8.4
	213	77.5
TOTAL	275	100.0

Nearly 3 out of 4 report an increase in the 1987 medical liability insurance premium as shown in Table 16. There were 11 reports of decreases, with an average decrease of 16.8%. The level of reported coverage change appears to be lower, probably due to prior activity making it difficult to change, and that 1987 only includes 6 months of the year. The average reported premium increase in 1987 is 30.5%. The overall net change is 27.7%. The average annual medical liability insurance premium in 1987 is $12,500.

Table 16. 1987 Premium Change.

	Frequency	Percent
Changed coverage		
No or same	31	11.7
Yes	33	12.5
	200	75.8
TOTAL	264	100.0

Table 17 shows that about 2 out of 3 of MAFP members have had a medical liability claim filed against them during the last 5 years. Table 18 shows that the percentage of physicians reporting claims varies only slightly by year, excepting 1986. 1986 seems to be the year with the most claims filed, and 1987 is only a partial year in this study. Table 18 shows very few differences in claims filed by various characteristics of the physicians and practices.

Table 17. Claims Filed.

	Frequency	Percent
No	131	37.8
Yes	216	62.2
TOTAL	347	100.0

Table 18. Claims Filed by Year.

	Percent
1983 claims	29.9
1984 claims	28.4
1985 claims	25.4
1986 claims	38.1
1987 claims	11.9

Table 19. Claims Filed by Sample Characteristics.

	Years certified by MAFP				
	1-5	5-10	11+	Total	
Yes	76.5	51.4	55.8	61.1	
	Deliver babies				
	Yes	No			
Yes	66.5	54.6		62.1	
	Perform surgery				
	Yes	No			
Yes	64.4	58.0		62.1	
	Type of practice				
	Single	Group	Other		
Yes	57.9	64.6	67.2	62.2	
	Type of community				
	Rural	Towns	Detroit	Cities	Total
Yes	59.5	57.7	64.3	67.3	62.2

The MAFP members were asked a hypothetical question about their medical liability insurance premium and their practice. Specifically the physicians were asked if insurance companies offered a 30% reduction in the medical liability premium if obstetrics were excluded, would they stop delivering babies. Table 20 shows that about half would discontinue obstetrics if this offer were made. A similar question was asked about surgery with a similar result.

Table 20. 30% Reduction If Part of Practice Excluded.

	1985		1987	
	Frequency	Percent	Frequency	Percent
Discontinue OB	119	47.8	117	55.7
Continue both	130	52.2	93	44.3
TOTAL	249	100.0	210	100.0
Discontinue surgery	127	48.5	127	53.6
Continue both	135	51.2	110	46.4
TOTAL	262	100.0	237	100.0

The physicians were also asked to estimate the probability of altering their practice at different levels of medical liability insurance premium increases. Table 21 shows the average estimates under conditions of reducing deliveries and stopping deliveries, at a 25% premium increase, a 50% premium increase, and a 100% premium increase. In general the probabilities are higher for stopping deliveries than reducing them. As the premium increase becomes greater, the difference widens in favor of stopping deliveries. At the level of a 100% premium increase, for example, the physicians estimate that there would be a 81% chance of reducing deliveries, and an 93% chance of stopping deliveries altogether. Clearly continued premium increases will result in more physicians electing to stop delivering babies.

Table 21. Estimated Response to Premium Increases.

	Average Probability
Reduce at 25%	23.95
Reduce at 50%	62.33
Reduce at 100%	80.68
Stop at 25%	32.63
Stop at 50%	76.65
Stop at 100%	92.92

Attitudes

The MAFP members were also asked their opinions on a variety of related items. Table 22 shows the result of question about the severity of the medical liability problem. Over 3 out of 4 rate the problem as the most severe or extremely severe medical practice problem.

Table 22. Severity of Liability Problem

	Frequency	Percent
Most severe problem	105	30.6
Extremely severe	160	46.6
One of many problems	72	21.0
Minor problem	6	1.7
TOTAL	343	100.0

Table 23 shows that nearly 3 out 4 believe that there are women in Michigan who are unable to get competent obstetrical care because of the medical liability problem. This is an increase from the 1985 level of just over half.

Table 23. Women Unable to Get Care.

	1985		1987	
	Frequency	Percent	Frequency	Percent
Yes	216	56.0	253	73.1
No	55	14.2	30	8.7
Not sure	115	29.8	63	18.2
TOTAL	386	100.0	346	100.0

Table 24 shows that nearly all MAFP members believe that the medical liability problem has led to practicing more defensive medicine. The proportion reported here has remained virtually unchanged since the 1985 study.

Table 24. More Defensive Medicine.

	Frequency	Percent
Yes	334	96.5
No	6	1.7
Not sure	6	1.7
TOTAL	346	100.0

Table 25 shows the aggregate ranking of five related issues to the medical liability problem. Ranked first most often is the threat of a law suit. Ranked second is no limit on potential liability awards. Ranked third is medical liability insurance premiums. Ranked fourth is liability exposure from negligence and maloccurence. Ranked fifth, and last, is the long statute of limitation.

Table 25. Ranking of Liability Related Issues.

	Ranking First Percent	Average Rank
Threat of law suit	36.3	2.51
Limit on liability	35.9	2.11
Insurance premiums	15.3	3.27
Maloccurence	11.6	3.62
Statute of limitation	6.8	3.24

CLAIMS EXPERIENCE AND MARKET CONDITIONS FOR MEDICAL MALPRACTICE INSURANCE

A REPORT BY THE

MICHIGAN COMMISSIONER OF INSURANCE

INSURANCE BUREAU
DEPARTMENT OF LICENSING AND REGULATION

PART I

BACKGROUND

"Crisis" can be defined as a turning point, a crucial or decisive time. It is in this context that the medical malpractice insurance "crisis" can be seen as an opportunity for problem definition and evaluation, for it is only through an objective look at the market that appropriate conclusions and solutions can be developed.

The concept of a medical malpractice insurance crisis is not a new one. The same concerns which were raised in the mid-1980s -- cost and availability of coverage -- were also raised in the mid-1970s. The solution of the '70s was to create a malpractice insurance fund to directly respond to the problem of availability and cost. The '80s, however, saw an approach designed to attack the underlying costs which drive the premiums through the adoption of what is generically termed tort reform. Data with which to evaluate the effect of the tort reforms of 1986 is not available. However, data regarding the medical malpractice insurance market and medical malpractice claims experience is available through the Insurance Bureau.

Public Act 44 of 1975 required insurers to submit detailed information on medical malpractice claims both when they are initially filed and at the time they are resolved. In 1986, the Legislature amended the reporting requirements to include self-insured entities and every person, other than an insurer, who pays or who has assumed liability to pay a medical malpractice claim. Attorneys who represent either a plaintiff or a defendant in a malpractice action, as individuals, must make initial and closed claim reports to the Insurance Bureau.

In an effort to monitor the medical malpractice insurance market, the 1986 legislation requires the Commissioner of Insurance to prepare a report every two years which describes the condition of the market, contains information regarding specific claims experience from reports filed with the Bureau, and makes recommendations concerning the market. This is the first such report.

The data on claims experience in this report is taken from the Insurance Bureau's data base for the years 1983 through the first six months of 1988. It should be noted that in sections of the report dealing with specific aspects or types of claims, the totals may not add to the totals reported for indemnity, expenses and claim reports by year. This is because not all forms contain entries in all fields.

PART II

THE MEDICAL MALPRACTICE INSURANCE MARKETPLACE

The market for medical malpractice insurance is made up of all of the sources from which health care providers can obtain professional liability insurance. The participants changed dramatically in the first medical malpractice crisis of the mid-1970s, and some less obvious but equally significant shifts have occurred as a result of the hardening of the liability insurance market which took place in the mid-1980s.

Sources of Medical Malpractice Insurance

In the early 1970s, the three largest writers of physicians' malpractice insurance in Michigan were the Medical Protective Company, Pacific Indemnity and Shelby Mutual. The three largest writers of hospital malpractice insurance were Aetna Casualty and Surety, Pacific Indemnity and Continental Casualty. By 1976, the three largest providers of physicians' malpractice coverage were the Brown-McNeely Fund created by the state legislature to insure physicians who could not otherwise obtain coverage, the Medical Protective Company and Michigan Physicians Mutual Liability Company, a new Michigan domestic insurer formed by physicians. For hospitals, the three largest writers of medical malpractice insurance in 1976 were the Argonaut Insurance Companies, Michigan Hospital Association Mutual Insurance Company and Hartford Accident and Indemnity. Shelby Mutual had abandoned the Michigan medical malpractice market completely and other major insurers such as Aetna Casualty, Pacific Indemnity and the Continental group were in the process of withdrawing.

Exhibit 1 lists the ten largest writers of medical malpractice insurance in Michigan at three points in time: immediately following the mid-1970s crisis, then during the relatively calm period of the early 1980s and finally the most recent calendar year, which followed another contraction in the general liability insurance marketplace. The exhibit illustrates several points about the Michigan malpractice market. First, entry to and exit from a particular line of insurance is extremely easy, as evidenced by the change in the ranking and mix of insurers at each point shown. Second, the specialty line of medical malpractice insurance is highly concentrated in a few insurers, and becoming more so, as the market share accounted for by the top four firms has increased from 61 percent in 1977 to 70 percent in 1982 to 84 percent by 1987. Third, the amount of premium generated by medical malpractice insurance sold by companies licensed in Michigan has increased by 124 percent over the past ten years. Most of the increase has occurred in the past few years, with 1987 written premiums exceeding 1982 volume by 92 percent.

EXHIBIT 1

TEN LARGEST WRITERS OF MEDICAL MALPRACTICE INSURANCE
(in thousands of dollars)

1977		1982		1987	
Company Name	Direct Premium Written	Company Name	Direct Premium Written	Company Name	Direct Premium Written
Medical Protective	$12,799	MPMLC	$ 19,909	MPMLC	$ 71,246
Argonaut Mid-West	11,728	Medical Protective	14,324	PICOM*	45,464
MPMLC	11,524	MHAMIC	12,041	MHAMIC	22,220
Brown-McNeely Fund	11,237	PICOM*	9,967	Natl Union Fire	7,284
MHAMIC	10,937	Hartford Accident	2,639	St Paul	6,454
Hartford Accident	6,105	St Paul	1,904	Medical Protective	4,982
Argonaut Insurance	3,654	Argonaut Midwest	1,878	Transportation Ins	3,844
Pacific Indemnity	2,974	Argonaut Ins	1,651	St Paul Mercury	2,352
St Paul	2,412	St Paul Mercury	1,399	American Continental	1,640
Vigilant	1,258	Ins Co of N America	1,206	Chicago Ins	1,612
All others	3,182	All others	6,445	All others	7,148
TOTAL	$ 77,710	TOTAL	$ 73,363	TOTAL	$174,246

* Successor to the Brown-McNeely Fund

SOURCE: Insurance Bureau, Annual Statements Filed by Insurers

Although insurance in general is an industry characterized by great ease of entry and exit, the medical malpractice line has shown a great amount of stability among the largest writers during recent years. After the medical malpractice crisis of the mid-1970s, this line became written predominately by specialty insurers formed by health care providers to meet their needs for professional liability insurance. Michigan was no exception, and by 1987 provider-owned domestic insurers accounted for 80 percent of direct written premiums. The dominance of provider-owned insurers was a direct outgrowth of the abandonment of the medical malpractice insurance market by multi-line insurers in the mid-1970s. While multi-line insurers such as the St. Paul Group, the Fireman's Fund Group (Chicago Insurance Company) and the CNA Group (Transportation Insurance Company) have continued to provide medical malpractice insurance to ancillary health professionals such as nurses, therapists, psychologists, pharmacists and medical technicians, only the Continental group (Continental Insurance Company) has attempted to re-enter the market for physicians' medical malpractice insurance. Continental's program of rates and forms for physicians' malpractice insurance was filed with and approved by the Michigan Insurance Bureau in 1988, so data measuring its impact is not yet available.

In addition to Continental, another new entrant to the medical malpractice insurance market in late 1988 was Butterworth Insurance Exchange, a reciprocal insurer formed by Butterworth Hospital in Grand Rapids to insure physicians who are members of the hospital's medical staff. This company continues the predominant pattern of health care providers sponsoring their own captive insurance programs to meet their liability insurance needs.

One of the differences between the hardening of the liability insurance market which occurred in the mid-1970s and the one which occurred in the mid-1980s was that after the latter event, many physicians turned to mechanisms other than the health care provider-sponsored programs which had been created after the first crisis. A number of large hospitals established offshore captive insurers to insure themselves and physicians with admitting privileges at their hospitals against medical malpractice liability. As a result, the number of Michigan physicians insured by companies licensed to do business in Michigan has declined. Exhibit 2 reflects the growing volume of malpractice insurance premiums written by non-admitted insurers and their increasing share of the medical malpractice market. Another source of medical malpractice insurance for health professionals was created when Congress amended the Product Liability Risk Retention Act of 1981 to form the Risk Retention Act of 1986 which allowed the formation of risk retention groups and purchasing groups for all types of liability insurance. A risk retention group is a member-owned liability insurer licensed in at least one state which may then provide liability insurance to all of its members/policyholders without having to be licensed

EXHIBIT 2

MEDICAL MALPRACTICE INSURANCE PREMIUMS WRITTEN BY NON-ADMITTED INSURERS
(in thousands of dollars)

Year	Premium*	% of Total Liability* Written by Non-Admitted Insurers	% of Total Medical** Malpractice Premiums
1982	5,465	9.8	5.7
1983	N/A	N/A	N/A
1984	13,124	20.5	11.6
1985	30,676	18.8	17.5
1986	48,431	20.3	20.2
1987	70,128	27.1	28.7
1988	72,353	27.7	NA

SOURCE:
*Insurance Bureau Semiannual Surplus Lines Statements
**Insurance Bureau Property & Liability By-Line Statistical Report

in each state where its members are located. A purchasing group is a group which purchases liability insurance on a group basis for its members in order to cover their similar or related liability exposure. The members of either a risk retention group or a purchasing group must be engaged in similar businesses or activities or exposed to similar liability by virtue of their trade, product, service, premises or operation.

Since the Risk Retention Act was passed, more than 50 risk retention groups and about 300 purchasing groups have been formed nationally. The most common purpose for the formation of purchasing groups has been to obtain professional liability insurance, most frequently medical malpractice insurance. Seven risk retention groups and thirty-two purchasing groups have filed information with the Insurance Bureau indicating their intent to provide medical malpractice insurance to their members in Michigan. A list of these risk retention groups and purchasing groups is included in Appendix B.

Public Act 173 of 1986 also provided for the creation of limited liability pools. Authorized by Chapter 65 of the Insurance Code, these pools may be used to issue liability policies for commercial, industrial or professional liability. Before a limited liability pool can be formed, the Commissioner of

Insurance must hold a public hearing and make a determination that the type of liability insurance to be offered by the pool is not readily available or not available at a reasonable premium for that type of coverage or class of risk.

In March, 1988, a committee of physicians requested a hearing to determine whether malpractice insurance was available or was not available at a reasonable premium in the western region of Michigan, including the Upper Peninsula. Following a public hearing and testimony from a consulting actuary, the Commissioner determined that a limited liability pool could not be formed to insure physicians in western Michigan because coverage was available at a reasonable premium.

The creation of domestic doctor and hospital-owned insurers, the re-entry of the market by a few foreign (non-Michigan domiciled) insurers, the formation of risk retention groups and the proliferation of offshore captives have resulted in more availability of medical malpractice insurance now than has existed for many years. However, this availability has some limitations. Most of the insurers domiciled in Michigan do not offer coverage limits in excess of $200,000 per occurrence/$600,000 aggregate. Those licensed insurers offering higher limits will do so only on a claims-made basis, even though lower limits are available on an occurrence basis. Risk retention groups and offshore captives may offer higher limits of coverage, but policyholders of these insurers are not protected by the Michigan Property and Casualty Guaranty Fund in the event of the insurers' insolvency. So even though basic coverage is widely available from a variety of sources, some physicians may still feel they are not able to find the amount of coverage they need under the terms they desire. Furthermore, some sources of malpractice insurance are only open to particular providers, such as those with admitting privileges at certain hospitals or certain types of specialists.

Pricing of Medical Malpractice Insurance for Physicians

The data on market structure for medical malpractice insurance in Michigan suggests an oligopolistic market -- a market dominated by a few firms, each of whom would tend to quickly lose market share if they raised their prices above the market price and would quickly gain market share at a lower price. The effect of this market structure is to keep insurers' rate levels very close together. Exhibits 3, 4, 5 and 6 show the base rates charged by the three largest writers of physicians' insurance coverage -- Michigan Physicians Mutual Liability Company, Physicians Insurance Company of Michigan and Medical Protective -- plus a newcomer, Butterworth Insurance Exchange. A description of the specialty areas included in each class may be found in Appendix D. The rates filed by Continental Insurance Company are not on a basis comparable to the rates in these exhibits.

EXHIBIT 3

MICHIGAN PHYSICIANS MUTUAL LIABILITY COMPANY

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory 1*	Territory 2**	Territory 3
I	$ 6,704	$ 4,013	$ 3,648
IB	8,033	4,825	4,386
II	9,238	5,551	5,047
III	14,985	9,004	8,185
IV	25,585	15,317	13,925
IVB	26,718	16,064	14,604
V	34,823	20,847	18,952
VB	36,364	21,864	19,877
VIA	46,965	28,117	25,561
VI	58,706	35,146	31,951
VII	68,705	41,131	37,392
VIII	74,952	44,871	40,792
VIIIB	79,594	47,804	43,458
IX	87,553	52,532	47,756

* Territory 1 includes Wayne, Oakland and Macomb counties.

** Territory 2 includes Bay, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Monroe, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola and Washtenaw counties.

EXHIBIT 4

PHYSICIANS INSURANCE COMPANY OF MICHIGAN

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory I*		Territory II
	M.D.	D.O.	
1	$ 6,601	$ 7,921	Territory II rates are determined by applying a factor of .60 to Territory I rates.
2	9,044	11,756	
2A	10,232	13,301	
3	14,522	18,878	
4	25,084	37,626	
5	27,724	41,586	
6	34,985	52,478	
8	58,749	88,123	
8A	64,690	97,035	

* Territory I includes Wayne, Oakland and Macomb counties.

EXHIBIT 5

MEDICAL PROTECTIVE COMPANY

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Area 1*	Area 2
1	$ 7,953	$ 4,881
2	15,111	9,274
3	19,883	12,203
4	23,859	14,643
5	46,127	28,310
6	54,876	33,679
7	63,624	39,048
8	71,577	43,929

* Area 1 includes Wayne, Oakland, Macomb and Genesee counties.

EXHIBIT 6

BUTTERWORTH INSURANCE EXCHANGE

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory 1*	Territory 2
I	$ 5,933	$ 3,559
IB	7,223	4,334
II	8,033	4,820
IIB	9,735	5,841
IIIA	11,208	6,725
III	13,030	7,818
IVA	17,997	10,798
IV	22,642	13,585
IVB	23,870	14,322
V	30,817	18,490
VB	33,292	19,975
VI	51,952	31,172
VIIA	55,908	33,545
VII	60,801	36,480
VIII	66,329	39,797
IX	79,594	47,756

* Territory 1 includes Wayne, Oakland and Macomb counties.

Virtually all of the insurers filing rates for physicians' medical malpractice insurance have combined Wayne, Oakland and Macomb counties into one rating territory. Medical Protective Company has included Genesee County in this group as well. The rates for the remainder of the state are approximately 60 percent of the rate charged for the same class in the higher territory. Michigan Physicians Mutual Liability Company has further divided the remainder of the state into two territories, one at 60 percent of the highest territory rates and another encompassing western Michigan and the Upper Peninsula at approximately 54.5 percent of the highest rate. Territorial rating is not new in medical malpractice insurance. Medical Protective and Shelby Mutual were using two territories for a number of years prior to the crisis of the mid-1970s.

Another rating factor which has changed over the years has been the classification of physicians into risk groups. Twenty-five years ago, there were only four classifications for physicians. In an attempt to further identify and separate out the better risk specialties within each classification, insurers have subdivided these groups. While the highest and lowest rates charged by each company do not vary greatly, there is considerable variance within that range between insurers. Medical Protective uses the least number of classifications at eight, while Butterworth Insurance Exchange has the most with sixteen. The class plans usually assign family practitioners, general practitioners and specialists in internal medicine with no surgery to class 2. Highest rated specialties are generally cardiovascular and thoracic surgery, obstetrical surgery, orthopedic surgery and neurosurgery. One of the highest rated specialties in the mid-1970s, anesthesiology, has experienced a relative decrease in risk and is now in the mid-range of classifications.

A factor in rating which has not changed over the years is whether the physician is an allopathic physician (M.D.) or osteopathic physician (D.O.). All of the filed rates for medical malpractice insurers in Michigan show a higher rate for D.O.s than M.D.s. In some cases, such as Physicians Insurance Company of Michigan, the insurer uses a separate rate schedule for M.D.s and D.O.s. In other cases, the insurer assigns D.O.s to a higher rate classification than an M.D. in the same specialty. Loss data filed by the insurers writing medical malpractice insurance has supported this differential, although there is no clear explanation for the difference in experience.

Physicians' medical malpractice insurance rates have been increasing rapidly for a long time. In the roughly five year period between June 1966 and October 1971, the rates recommended by the Insurance Services Office for physicians' medical malpractice coverage for limits of $100,000/$300,000 increased by 275 percent for physicians in the lowest rated classification and 562 percent for specialties in the highest rated class. By 1976, five years later, the lowest rated physicians' rates had increased from $458 charged by Pacific Indemnity for $100,000/$300,000 limits to $1,100 or $1,500 charged by Michigan Physicians Mutual Liability Company, depending on territory. Exhibit 7 shows a rate history for the three largest writers of physicians' insurance, from the inception of MPMLC in 1976 and PICOM in 1980 to the present time.

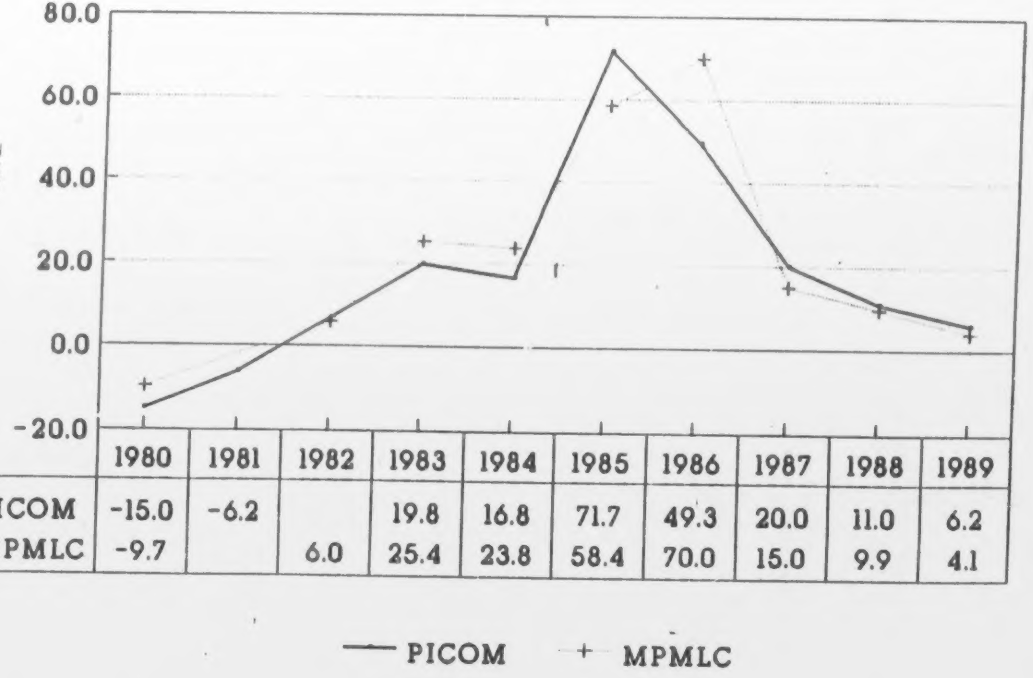
EXHIBIT 7

PHYSICIANS' MEDICAL MALPRACTICE RATE HISTORY FOR THREE LARGEST INSURERS

Effective Date	Percent Change MPMLC	PICOM	Medical Protective
1- 8-78	- 2.2		
7- 1-79	- 5.0		
7- 1-80		-25.3	
10- 1-80		10.3	
11- 1-81	- 9.7		
4- 1-81		- 6.2	
7- 1-82	6.0		
4- 1-83	25.4	19.8	
6- 1-83			30.0
5- 1-84			44.2
5-15-84		16.8	
6- 1-84	23.8		
3- 1-85		48.0	
4- 1-85	58.4		
7- 1-85			55.0
12-15-85		23.7	
2- 1-86	70.0		
3-31-86		49.3	
7- 1-86			51.6
10- 1-86	1.0		
4- 1-87	15.0		
6- 1-87		20.0	
6- 1-88	9.8		
6-15-88		11.0	

A graph of MPMLC's and PICOM's rate history illustrates more clearly how their rates have stayed close together. As a market with a small number of sellers, medical malpractice insurers are aware that if they raise their prices too far above their competitors' levels, they will lose market share. The large increases filed in 1985 were done at the insistence of the Insurance Bureau, which was concerned about loss development trends and the adequacy of the malpractice insurers' reserves. Another large increase to bring rates and reserves to more adequate levels was taken by the insurers in 1986. Since that time, rate increases have been considerably more moderate. One insurer, Medical Protective Company, has not filed for a rate change since 1986. However, the company has been steadily

RATE FILING HISTORY
MD'S AND DO'S ONLY



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
PICOM	-15.0	-6.2		19.8	16.8	71.7	49.3	20.0	11.0	6.2
MPMLC	-9.7		6.0	25.4	23.8	58.4	70.0	15.0	9.9	4.1

5/23/89

SOURCE: Physicians Insurance Company of Michigan decreasing the number of doctors it insures in Michigan, as evidenced by a decline in the net premiums written beginning in 1984 despite increases in malpractice rates.

Pricing of Medical Malpractice Insurance for Hospitals

A General Accounting Office report (HRD-86-112 Sept. 1986) indicated that from 1983 to 1985, total inpatient hospital days for the nation as a whole decreased by 13 percent while hospital malpractice insurance costs increased by approximately 57 percent, from $849 million to $1,336 billion. As a result, the average cost for malpractice insurance per inpatient day increased by 85 percent, from $3.02 to $5.60.

To help reduce costs, hospitals took one or more of the following steps: 1) retained some or all of the malpractice risk themselves through self-insurance trusts; 2) switched from an occurrence to a claims-made policy; 3) added or increased deductibles; and 4) decreased coverage limits. Michigan mirrored these national trends as the larger hospitals in the Wayne, Oakland and Macomb areas became self-insured or formed offshore captives. Currently, the Insurance Bureau estimates that over 50 percent of the hospital beds in Michigan are self-insured.

The primary insurer of hospitals in Michigan who remain with conventional malpractice insurance is the Michigan Hospital Association Mutual Insurance Company (MHAMIC). Like the two largest writers of physicians' malpractice insurance in Michigan, MHAMIC is a captive formed by its member insureds to meet their needs for medical malpractice insurance. The only other insurer still writing small amounts of hospital malpractice insurance in Michigan is St. Paul Insurance Company. Argonaut Insurance Company withdrew from the hospital liability market in mid-1985. As Exhibit 1 showed, Argonaut's market share had already decreased dramatically by 1982.

Determining premiums for hospital professional liability insurance is more complex than for physicians' professional liability. As for physicians, base rates are set at limits of $100,000 per occurrence and $300,000 aggregate. The units of exposure are the number of beds available for patients and the number of emergency room and outpatient visits. Factors are then applied to the base rate to determine rates for higher limits of liability. Other factors may also be used, such as experience modification factors to reflect each hospital's recent loss experience, discounts for deductibles and claims-made factors which provide for a reduced premium in the first few years of a claims-made policy. Special characteristics of each hospital, such as number of bassinets, number of psychiatric or rehabilitation beds, and other special services or programs provided by the hospital are also considered in calculating final premiums for hospital liability insurance.

Like physicians' medical malpractice insurance, hospital malpractice insurance is also rated by territory. MHAMIC currently uses three rating territories:

Territory 1. Macomb, Oakland and Wayne counties.

Territory 2. The area within the limits of the following cities:

Ann Arbor
Battle Creek
Bay City
Benton Harbor
Flint
Grand Rapids
Jackson
Kalamazoo
Lansing
Midland
Muskegon
Niles
Port Huron
Saginaw
St. Joseph
Ypsilanti

Territory 3. Remainder of state.

Exhibit 8 provides a rate history for MHAMIC for basic limits of coverage per acute care bed. While this is overly simplistic, it does provide a general indication of the magnitude and direction of final premiums. An interesting development is that MHAMIC lowered its acute care bed rate in 1988 by 10 percent for Territory 1 and 2, and by 20 percent for Territory 3.

EXHIBIT 8

MICHIGAN HOSPITAL ASSOCIATION MUTUAL INSURANCE COMPANY ACUTE CARE BED RATE HISTORY

Acute Care Bed Rate Charged for $100,000/$300,000 Limits, Occurrence Form

Rating Period	Territory 1	Territory 2	Territory 3
1977-1978	$ 450	$	$
1979-1981	399		
1982	465		
1983	1,055		
1984	1,368	1,368	1,053
1985	2,736	1,847	1,316
1986	3,420	2,309	1,645
1987	4,617	3,118	2,221
1988	4,155	2,806	1,777

Note: Prior to 1984, MHAMIC did not differentiate acute care bed rates by territory.

Merit Rating

One of the many requirements of P.A. 173 of 1986 was that all commercial liability insurers, including medical malpractice insurers, adopt merit rating plans for their commercial liability insurance products. Section 2404(1) of the Insurance Code, MCLA 500.2404, specifies that "[a] merit rating plan required under this section shall adjust rates for commercial liability insurance policies on the basis of risk management techniques implemented by the insured."

In addition, medical malpractice insurers were permitted to surcharge their policyholders based on their claim experience under certain limited circumstances. Section 2404(2) listed four requirements which such a surcharge must meet:

1. The surcharge plan must be filed with the commissioner.
2. The surcharge must not be based on an action that was filed more than three years before the issuance or renewal of the policy.
3. The surcharge must not be based on an action for which the insured has been found not liable or which was settled or dismissed without indemnity being paid on behalf of the insured.
4. The surcharge must not be based on an action for which the insurer paid in indemnity and loss adjustment expenses an amount less than 51 percent of the annual premium paid for the policy covering the action.

Medical malpractice insurers have filed experience rating formulas which compare losses meeting the above criteria to expected losses under the policy in order to calculate credits and debits.

The merit rating plans based on risk management activities accept a variety of measures aimed at reducing or eliminating medical malpractice claims. Credits are given for completion of approved risk management seminars, approved office risk analysis and education programs, and approved closed claim review programs. Implementation and use of an approved patient information system is also a basis for merit rating credit. Specialists may be eligible for credits by complying with risk management and loss prevention guidelines adopted by their recognized medical specialty societies. Exhibit 9 shows examples of merit rating credits given by the major medical malpractice insurers.

Claims-made Policy Forms

A recent development affecting the pricing of medical malpractice insurance for physicians and other health practitioners has been the approval by the Insurance Bureau of the claims-made policy form for this type of coverage. Historically, medical malpractice liability insurance was offered on an occurrence basis, with the policy indemnifying the insured for all loss-producing events which occurred while the policy was in force, regardless of when the claim for the loss was finally made.

EXHIBIT 9

MERIT RATING PLANS

Recommendations for Hospital Insurers

ISO

Maximum credit	25%
Examples:	10% for medical audit system including surgical procedures tied to physician credentialing
	2% for continuing education
	5% for JCAH or AOA accreditation
	10% for compliance with loss prevention recommendations

MPMLC

Maximum credit	8%
Examples:	Completion of approved office risk analysis
	Attendance at approved risk management seminar carrying 3 CME credits
	Closed claim review carrying 2 CME credits

MHAMIC

Maximum credit	25%

MEDICAL PROTECTIVE

Maximum credit	5% for completion of 2 eight-hour risk management seminars

PICOM

Maximum credit	10%
Examples:	5% for level one program - completion of internal office review, attendance at risk management seminar minimum four hours
	10% for level two program - completion of two characteristics of level one program plus completion of a specialty society risk management seminar or self-assessment survey

A claims-made policy indemnifies the insured for losses for which a claim is made while the policy is in force, provided that the loss producing event occurred after the initial date of coverage under the policy. For liability insurance which typically has a lag between when an incident occurred and when a claim is made, this has the effect of moving losses into later years of coverage under the policy. As a result, there is a substantial discount for claims-made policy premiums compared to those of occurrence policies during the early years of a policy. The discount tapers off until, at about five years, the claims-made rates are virtually identical to occurrence rates. The effect of claims-made policies on malpractice rates for physicians is illustrated by Exhibit 10.

EXHIBIT 10

**CLAIMS MADE RATE FACTORS
AS A PERCENTAGE OF OCCURRENCE PREMIUMS**

Year of Coverage	MPMLC	PICOM	Butterworth
1st	50%	50%	50%
2nd	70%	70%	70%
3rd	85%	85%	85%
4th	90%	90%	95%
5th and beyond	95%	95%	100%

SOURCE: Rates on file with the Michigan Insurance Bureau as of 12/31/88.

When a claims-made policy ends, however, it is necessary for the policyholder to pay additional premiums to buy coverage for claims which may be reported after that date on events which occurred while the policy was in force. A claims-made policy in effect changes the payment pattern for liability insurance, reducing the cost in the early years and increasing the cost at the end of the contract.

The advantages of a claims-made policy to the insured are the obvious decrease in cost in the early years which can be important to persons just starting a business or profession, and the ability to increase protection limits as inflation or assets require. The major disadvantage is the need to purchase coverage for an "extended reporting period" for claims which are made after the policy ends. A policyholder with a claims-made policy faces a potentially large expense for coverage for this extended reporting period at retirement, death, cessation of business, or even when changing insurance carriers.

Medical malpractice insurers offering claims-made policies have attempted to alleviate some of the disadvantages of these policies by waiving the premium for the extended reporting period in the event of death or disability of the insured or for normal retirement, provided the covered person was insured by the company for at least five years prior to this event. They have also offered graded premiums for the extended reporting period during the first few years of practice for new physicians who have just completed their medical training.

There are fewer disadvantages to a claims-made policy for hospitals than for doctors. Hospitals as corporations have a theoretically perpetual life and do not face the problems of eventual retirement and death. Hospitals also do not need to be concerned about the possible difficulty of relocating, as a physician might. For these reasons, claims-made policies have been accepted for use in insuring hospitals for a longer time than they have been used to insure physicians.

Although claims-made policies have made major inroads in insuring Michigan physicians, as well as most other types of health-related professions, all three of the major physician insurers continue to insure some portion of their policyholders on an occurrence basis. PICOM has been most active in marketing the claims-made form, and will accept new insureds only on that basis. MPMLC offers both forms of coverage, and Medical Protective uses only occurrence policies. Of the newer participants, Continental offers only the claims-made form, while it appears that Butterworth Insurance Exchange will carry both occurrence and claims-made. It seems that the two different forms of coverage will be able to co-exist in the Michigan malpractice insurance market, at least for the foreseeable future.

Demand for Malpractice Insurance

No discussion of a marketplace would be complete without some consideration of the demand for the product. For medical malpractice insurance, demand is correlated with the number of hospitals, physicians and other health care providers. Exhibit 11 was prepared by the Office of Health and Medical Affairs. Using data supplied by the American Medical Association and the American Osteopathic Association, it reports the growth in the number of physicians in Michigan over a 15 year period. Despite the large increases in the cost of medical malpractice insurance over that period, the number of active physicians in Michigan has continued to rise.

Exhibit 12 is ambiguous as to whether medical malpractice insurance costs may be redistributing the number of physicians in certain specialties. While the total number of M.D.s in Michigan increased by 39.2 percent over the 12 year period shown, some specialties such as cardiovascular and pulmonary medicine increased by more than 100 percent while growth in occupational medicine was nearly flat. Among the surgical specialities, general surgery experienced the least growth at 10.6 percent, followed by obstetrics and gynecology at 17 percent. However, orthopedic surgery and plastic surgery, both fairly highly rated for malpractice insurance purposes, experienced above average growth.

Unlike physicians, the number of hospitals in Michigan has decreased in the fifteen years between 1973 and 1988. In 1973 there were 247 hospitals in the state, compared to 204 in 1988. The number of available hospital beds decreased from 41,331 in 1973 to 37,556 in 1988, or an average reduction of about 88 beds per closed hospital. It is clear that the hospitals which have closed have generally been smaller hospitals, which are the ones most likely to have remained in the insurance marketplace, using conventional insurance to meet their malpractice insurance needs. These small hospitals have succumbed to a number of economic pressures. Given the recent rate decreases made by the principal writer of hospital malpractice insurance in Michigan, however, it does not seem that malpractice costs will be the critical factor in the continued existence of small hospitals in the near future.

EXHIBIT 11

PHYSICIAN SUPPLY IN MICHIGAN AND THE U.S., 1971-1986

Category	1971	1981	1986	Total Change 1971-1986
Michigan				
Active Physicians				
DOs	2,168	3,040	3,401	56.9%
MDs	11,356	15,173	16,509	45.4%
Total	**13,524**	**18,213**	**19,910**	**47.2%**
Population	8.974	9.210	9.139	1.8%
Physicians per 100,000 Population	50.7	197.8	217.9	44.6%
United States				
Active Physicians				
DOs	12,560	18,275	23,647	88.3%
MDs	324,883	449,047	521,030	60.4%
Total	**337,443**	**467,322**	**544,677**	**61.4%**
Population	206,827	229.637	241.096	16.6%
Physicians per 100,000 Population	163.2	203.5	225.9	38.5%

NOTE: MD data is for 12/31/71, 12/31/81 and 12/31/86. DO data is for 1971, 3/31/81 and 8/1/86. Population data is for 7/1/71, 7/1/81 and 7/1/86.

SOURCE: American Medical Association, "Physician Characteristics and Distribution in the U.S." (Data adjusted by OHMA for address unknown, federal and unclassified physicians.)

American Osteopathic Association, "Yearbook and Directory of Osteopathic Physicians" and "Osteopathic Physicians in the United States: Report on a 1971 Survey." (Data adjusted by OHMA for federal, unclassified and non-responding physicians.)

Office of Health and Medical Affairs, 12/88

EXHIBIT 12

MICHIGAN PHYSICIAN ACTIVITY BY SPECIALTY

Year	1974	1975	1976	1977	1978	1979
Total Phys	12,608	13,176	13,519	13,594	14,290	14,593
Specialty						
Cardiovascular	184	212	188	200	242	239
Dermatology	153	161	167	176	186	193
Gastroent	51	67	60	72	91	94
Internal Medicine	1,676	2,000	2,145	2,245	2,297	2,516
Pediatrics	692	738	761	794	828	887
Pulmonary	47	46	47	48	81	85
Surgical						
General Surgery	1,184	1,274	1,311	1,266	1,248	1,300
Neuro Surgery	84	86	88	104	97	102
Obstetrics & Gynecology	859	903	931	942	965	1,011
Opthalmology	346	364	373	357	365	395
Orthopedic Surgery	315	329	338	356	379	412
Plastic Surgery	68	73	81	84	90	109
Urology	206	214	219	231	240	246
Other						
Anesthesiology	343	332	356	394	399	428
Diag Radiology	79	91	95	121	167	244
Neurology	84	96	102	105	114	142
Occupational Medicine	131	125	132	122	136	140
Psychiatry	790	783	803	802	828	901
Pathology	393	405	405	414	416	436
Radiology	469	475	491	478	430	421

Exhibit 12 (continued)

MICHIGAN PHYSICIAN ACTIVITY BY SPECIALTY

Year	1980	1981	1982	1983	1984	1985	1986
Total Phys	15,347	15,758	16,208	16,512		17,206	17,549
Specialty							
Cardiovascular	289	296	325	334		354	396
Dermatology	201	221	231	233		229	234
Gastroent	115	122	132	140		154	168
Internal Medicine	2,577	2,651	2,813	2,854		3,040	2,973
Pediatrics	942	945	967	974		1,066	1,058
Pulmonary	110	111	127	125		121	134
Surgical							
General Surgery	1,303	1,317	1,359	1,354		1,374	1,310
Neuro Surgery	107	111	124	120		120	121
Obstetrics & Gynecology	1,057	1,057	1,067	1,100		1,128	1,091
Opthalmology	410	411	430	432		449	452
Orthopedic Surgery	431	449	494	502		516	515
Plastic Surgery	102	105	116	120		123	130
Urology	257	262	266	273		281	268
Other							
Anesthesiology	435	455	496	510		529	567
Diag Radiology	261	303	388	422		492	523
Neurology	154	156	179	178		202	224
Occupational Medicine	137	142	129	126		129	134
Psychiatry	905	902	951	987		956	995
Pathology	449	460	479	486		502	497
Radiology	420	395	366	368		350	285

SOURCE: AMA, "Physician Characteristics and Distribution in the U.S."

PART III

MALPRACTICE CLAIMS EXPERIENCE

One of the purposes of this report is to provide an overview and analysis of medical malpractice actions for which reports have been filed with the Insurance Bureau since January 1, 1983. This will be done in two sections. The first section will review data obtained from Form A, the initial report of court action. The second section will consider data obtained from Form B, the closed claim report. It should be noted that self-insured institutions and individuals were not required to report malpractice actions until July, 1986. Therefore, the data base does not contain self-insured experience prior to that date. The data reporting forms are shown in Appendix A.

Initial Report of Court Action

This initial report, referred to as Form A, is required to be filed within thirty days after a complaint is filed in court. The information submitted on this report includes the defendant's name, specialty, date of incident, nature of the complaint and the county and court in which the complaint is filed.

The numbers below indicate the total initial reports filed from January 1, 1983 to June 30, 1988.

TABLE 1

TOTAL INITIAL REPORTS BY YEAR

Year	Records Filed
1983	1,925
1984	2,999
1985	3,105
1986	3,629
1987	2,397
1988 (through 6/88)	871
TOTAL	**14,926**

It appears from this data that the number of malpractice actions filed each year has begun to decrease, having peaked in 1986. It should be noted, however, that the high number of claims filed in 1986 may be partially attributed to the effort by the plaintiff's bar to file cases prior to the effective date of the tort law changes.

ACTIONS BY COUNTY

review of the claims filed by county shows that almost two-hirds of all actions are filed in three counties -- Wayne, akland and Macomb. The ten counties with the highest number of laims filed account for 83 percent of all claims. Twenty-four ounties showed ten or fewer total claims for the period anuary 1, 1983 to June, 30 1988. Although information on things uch as the number of patient visits, services performed and mergency treatments given may be more meaningful for purposes of omparing actions by county, lack of such data requires that ubstitute variables such as population and availability of edical services be considered instead. Not surprisingly, the ounties with the highest number of claims are those with large rban centers, medical schools and larger hospitals. Those with he fewest claims tend to be in the largely rural areas of the rthern lower peninsula and in the upper peninsula. Initial ions by county, by year, for the ten counties with the most aims are shown below:

TABLE 2

INITIAL ACTIONS BY YEAR -- TEN LARGEST COUNTIES

ounty	1983	1984	1985	1986	1987	1988	Total
ayne	883	1,421	1,408	1,625	1,114	347	6,798
akland	276	397	415	502	316	136	2,042
acomb	116	190	207	202	126	43	884
enesee	72	154	116	144	110	35	631
Ingham	53	107	133	110	65	16	484
Kent	42	72	85	100	74	35	408
ashtenaw	60	66	75	92	53	20	366
Kalamazoo	27	26	77	60	46	18	254
Jackson	37	40	70	53	26	6	232
aginaw	32	43	38	43	28	42	226
TOTAL							12,325

ACTIONS BY SPECIALTY

The Form A data shows that the largest number of claims are filed against six specialties. Claims by year by specialty are shown below:

TABLE 3

INITIAL ACTIONS BY YEAR -- SIX SPECIALITIES

Specialty	1983	1984	1985	1986	1987	1988	Total
Obstetrics	198	285	257	276	181	88	1,285
Internal Med*	159	236	183	93	26	12	709
Gen Practice*	154	327	113	62	10	8	674
Internal Med**	2	3	144	247	176	60	632
Orthopedics	100	182	113	106	59	20	580
Dentistry	131	107	113	68	21	13	453

* minor surgery
** no surgery

The decreasing number of claims filed against these specialists in 1987 and 1988 reflect the overall trend. It is interesting to note the pattern that occurred within each specialty, however.

Obstetricians continue to have the highest number of claims, but are following the overall pattern of fewer claims for the years 1987 and 1988. In 1984, more claims were filed against general practitioners doing minor surgery than any other specialist, having more than doubled since 1983. Since 1984, however, the number of claims against this specialty have decreased dramatically.

Internal medicine specialists performing minor surgery show a claim pattern similar to that of general practitioners performing minor surgery, with the highest number of claims being filed in 1984 and a dramatic decrease in claims in the years following. Internists performing no surgery, however, have experienced considerably different claim activity. Form A data shows only two claims filed against internists performing no surgery in 1983 and three claims in 1984. This increased to 144 claims in 1985, and in 1986 and 1987 they had the second highest number of claims filed with 247 and 176, respectively.

There are several possible explanations for the dramatic reduction in claims filed against general practitioners and internists performing minor surgery. It could be that physicians have made even more efforts in risk management, resulting in fewer patient difficulties and therefore fewer claims. It is also possible that the tort reform changes of 1986 have had an impact on the number of initial claims. Another factor could be that fewer general practitioners and internists are performing minor surgery than in previous years. Because there is no way to determine how many of these physicians have discontinued their surgical practice, we are unable to determine whether the ratio of claims to the number of practitioners has changed over the six-year period.

The factors cited above cannot totally explain the increase in claims experienced by internists performing no surgery, however. Interestingly, the sudden increase in claims against these practitioners coincides with the decrease in claims against general practitioners and internists performing minor surgery. One explanation could be that surgery is not necessarily the activity giving rise to the claims against internists. In fact, looking at the combined data for both classes of internists, a pattern of claim experience very similar to overall claim experience emerges. A review of the nature of initial claims shows that the treatment itself, misdiagnosis, and delay in diagnosis were the most common sources of medical malpractice claims against general practitioners and internists, regardless of whether they perform surgery.

Another somewhat related factor in the claim experience of internists could be a result of risk management on the part of other physicians. It may be that general practitioners are referring more patients to internists (and possibly other specialists) than they have in the past. Again, this is not verifiable with data available to the Bureau.

Closed Claim Reports

The closed claim report, referred to as Form B, is required to be filed within 30 days after any judgment, settlement or dismissal of a claim. The information submitted on this report includes identifying information on the insured, how the claim was resolved, the type and severity of the injury, and indemnity and expense payments.

The numbers below indicate the total closed claims filed, total indemnity paid, and total allocated expenses per year from January 1, 1983 to June 30, 1988.

TABLE 4

TOTAL CLOSED CLAIMS, INDEMNITY & ALLOCATED EXPENSES BY YEAR

Year	Closed Claims	Indemnity	Allocated Expenses
1983	1,740	$ 30,435,447	$ 21,833,548
1984	1,182	14,027,677	6,844,007
1985	2,177	59,056,089	18,444,727
1986	2,029	43,191,136	23,338,690
1987	3,586	106,137,543	68,592,244
1988 (through 6/88)	1,889	46,998,467	40,708,557
Total	12,603	$299,846,359	$179,761,773

TIME INTERVAL

It has been said that medical malpractice suits are more costly because they are more time-consuming than many other types of liability litigation. A review of the Insurance Bureau's closed claims data base (1983-1988) for the purpose of examining the length of time from the date of injury to the date of closure reveals that only 1 percent of malpractice actions are closed within one year and 5 percent are closed within two years. Approximately half of the cases take three to five years after date of injury to resolve.

Table 5 shows how many claims were closed during each 180 day interval.

TABLE 5

NUMBER OF CLAIMS CLOSED
180 DAY INTERVALS

Interval (Days)	Count
0 - 180	25
181 - 360	74
361 - 540	170
541 - 720	357
721 - 900	675
901 - 1,080	1,066
1,081 - 1,260	1,519
1,261 - 1,440	1,641
1,441 - 1,620	1,687
1,621 - 1,800	1,493
1,801 - 1,980	1,085
1,981 - 2,160	716
2,161 - 2,340	495
2,341 - 2,520	378
2,521 - 2,700	270
2,701 - 2,880	226
2,881 - 3,060	161
3,061 - 3,240	149
3,241 - 3,420	130
3,421 - 3,600	86
Over 3,600	462
Totals	12,865

Based on the available data, the length of time it takes to resolve a medical malpractice claim does not necessarily have a direct bearing on the ultimate indemnity. While it is true that the average indemnity for cases resolved within one year is considerably lower than for other time intervals, the average indemnity does not rise proportionately with the length of time between injury and resolution. In fact, average indemnity for cases resolved in three and one-half years or more generally remains between $20,000 and $40,000, regardless of the length of time. The reason for this is the fact that there are as many small awards (less than $5,000) as large ones for any given time interval. The median indemnity for cases resolved in three and one-half years or less is $0, and does not rise above $5,000 until cases almost ten years old are taken into account.

It could be assumed that the cases which result in an indemnity of $1 million or more would be the most complicated and therefore take longer to resolve. The data reported to the Insurance Bureau would not support such an assumption. Indemnity payments of $1 million or more are made in cases resolved within two and one-half years as well as those taking eight years to resolve. Exhibit 13 illustrates the range of indemnity payments in 180-day intervals.

EXHIBIT 13

INDEMNITY BY TIME INTERVAL BETWEEN DATES OF INJURY AND CASE CLOSURE

Interval (Days)	Average	Median	Minimum	Maximum
0 - 180	9,068	0	0	85,000
181 - 360	3,587	350	0	35,000
361 - 540	13,130	0	0	500,000
541 - 720	18,488	0	0	750,000
721 - 900	17,697	0	0	1,177,733
901 - 1080	17,304	0	0	900,000
1081 - 1260	17,899	0	0	750,000
1261 - 1440	19,224	1,000	0	1,000,000
1441 - 1620	21,169	2,000	0	837,887
1621 - 1800	27,118	4,000	0	1,000,000
1801 - 1980	23,743	2,500	0	690,689
1981 - 2160	29,065	3,800	0	900,000
2161 - 2340	35,599	5,000	0	682,078
2341 - 2520	30,844	1,676	0	1,293,000
2521 - 2700	29,945	899	0	949,590
2701 - 2880	27,379	2,846	0	405,243
2881 - 3060	52,271	2,500	0	2,354,474
3061 - 3240	34,338	4,000	0	733,530
3241 - 3420	32,557	1,125	0	885,248
3421 - 3600	37,705	1,750	0	966,743
Over 3600	40,181	6,000	0	596,446

Like indemnity payments, based on the Bureau's claim data, allocated expenses do not appear to be directly related to the length of time between injury date and resolution. For cases resolved within one year, average expenses are noticeably lower than for cases taking longer to resolve. With one exception, average allocated expenses are less than $25,000 regardless of time interval. Exhibit 14 shows average allocated expenses in 180-day time intervals.

These averages should be looked at with caution, however, because the actual allocated expenses for individual claims vary greatly within each time interval. This is demonstrated by the standard deviation. The smaller the standard deviation, the closer the actual numbers are clustered around the average; the larger the standard deviation, the wider the distribution. As the chart shows, allocated expenses are neither consistent within a given time interval nor across the data base as a whole. This is to be expected, since the cost to defend a particular claim depends in large part on the nature of the claim itself.

CLAIM RESOLUTION

The overwhelming majority of medical malpractice claims are resolved through settlement by the parties, although 1987 and 1988 show a decrease in the percentage which are settled. As indicated in Table 6, through 1986, over 90 percent of claims closed each year were settled, while only a small number were resolved by trial verdict, mediation or arbitration.

TABLE 6

CLOSED CLAIM RESOLUTION

Resolution	1983	1984	1985	1986	1987	1988
Settled by Mediation	22	52	39	27	247	181
Settled by Parties	709	933	1,892	1,800	3,034	1,512
Trial Verdict	2	27	115	135	194	144
Arbitration	5	8	10	18	18	11
	738	1,020	2,056	1,980	3,493	1,848

The data show that the percentage of cases resolved through mediation has increased from 1 percent in 1986, to 7 percent in 1987, and 10 percent for the first half of 1988, which may be attributable to the mandatory mediation provisions of Public Act 178 of 1986. It is interesting, however, that the increased mediation has not resulted in a decrease in cases resolved by trial verdict. Instead, there appears to be a shift from "settlement" to "mediation."

EXHIBIT 14

ALLOCATED EXPENSES BY TIME INTERVAL BETWEEN DATES OF INJURY AND CASE CLOSURE

Interval (Days)	Count	Average	Std.Dev
0 - 180	25	4,502	6,010
181 - 360	74	4,096	9,211
361 - 540	170	6,507	26,554
541 - 720	357	7,071	48,273
721 - 900	675	6,806	25,089
901 - 1,080	1,066	9,183	60,330
1,081 - 1,260	1,519	11,573	81,067
1,261 - 1,440	1,641	11,710	88,771
1,441 - 1,620	1,687	15,383	137,610
1,621 - 1,800	1,493	16,628	138,792
1,801 - 1,980	1,085	13,440	83,075
1,981 - 2,160	716	16,362	60,155
2,161 - 2,340	495	16,309	67,925
2,341 - 2,520	378	18,721	127,303
2,521 - 2,700	270	13,817	30,377
2,701 - 2,880	226	17,313	87,082
2,881 - 3,060	161	23,181	148,797
3,061 - 3,240	149	21,576	110,150
3,241 - 3,420	130	11,010	11,943
3,421 - 3,600	86	71,801	563,514
Over 3,600	462	13,499	82,243

CLOSED CLAIMS - SEVERITY OF INJURY

Form B establishes nine categories by which to describe the severity of the injury giving rise to each claim. They are:

1 - **Emotional Only** - Fright, no physical damage.

2 - **Temporary-Insignificant** - Lacerations, contusions, minor scars, rash, no delay.

3 - **Temporary-Minor** - Infections, mis-set fracture, fall in hospital. Recovery delayed.

4 - **Temporary-Major** - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

5 - **Permanent-Minor** - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

6 - **Permanent-Significant** - Deafness, loss of limb, loss of eye, loss of one kidney or lung.

7 - **Permanent-Major** - Paraplegia, blindness, loss of two limbs, brain damage.

8 - **Permanent-Grave** - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

9 - **Death**

Table 7 shows the distribution of closed claims by severity.

TABLE 7

NUMBER OF CLOSED CLAIMS BY SEVERITY

Category	1983	1984	1985	1986	1987	1988
1	59	39	69	59	95	61
2	79	67	93	90	149	92
3	417	315	471	439	678	313
4	121	93	155	172	258	126
5	256	185	382	299	506	220
6	186	133	246	203	465	231
7	83	39	139	134	270	164
8	60	23	66	52	151	77
9	453	274	503	526	946	565

Claims for death of the patient constitutes 26 percent of the closed claims for the five and one-half year period, the largest severity category. Category 3, Temporary-Minor, had the second highest number of claims (21%). It is interesting to note that there are almost as many claims for minor injuries as there are for major ones. Categories 1, 2, 3 and 5 contain 40 to 50 percent of the total closed claims each year.

In general, the claims for minor injuries account for 30 percent or less of the total indemnity paid in a given year. The percentage they represent of total expenses, however, is somewhat higher. Table 8 shows the percentage minor claims categories 1, 2, 3 and 5 represent of the total expenses and total indemnity payments.

TABLE 8

MINOR CLAIMS AS A PERCENTAGE OF TOTAL INDEMNITY AND TOTAL ALLOCATED EXPENSES

Year	% of Total Indemnity	% of Total Allocated Expenses
1983	21%	26%
1984	31%	42%
1985	18%	38%
1986	42%	58%
1987	29%	40%
1988	14%	35%

The data suggests that while minor injuries do receive lower indemnity payments, the expenses associated with these claims do not necessarily reflect the level of severity.

Appendix C shows indemnity and expense totals by category by year.

EXPERIENCE IN LARGER COUNTIES

The indemnity and expense costs associated with medical malpractice claims in the larger counties -- particularly Wayne, Oakland and Macomb -- continues to be a major topic of discussion. It is therefore worthwhile to look at the larger counties separately and to compare them to claims in the remainder of the state as well as the state as a whole.

A review of closed claims by county shows that over sixty percent of all claims closed are in Wayne, Oakland and Macomb counties. Not surprisingly, the ten counties with the highest number of closed claims are the same counties with the highest number of initial claims. These counties account for almost three-fourths of the total number of closed claims in each of the years studied. Since the number of closed claims reflects, in large part, the amount of litigation in an area, a more accurate measure of the cost of medical malpractice is the number of claims closed with an indemnity greater than $0. The expenses incurred in conjunction with malpractice claims and the following chart shows the total number of closed claims and the number of claims closed with an indemnity greater than $0.

Data on the total number of closed claims and the number of claims closed with an indemnity greater than $0 shows that, in general, 50 to 60 percent of claims closed between 1983 and 1988 actually involve payment of an indemnity to the claimant. This holds true whether one looks at the ten largest counties individually or as a group, the remainder of the state, or the state as a whole. Exhibit 15 shows the number of closed claims and the number of closed claims with an indemnity greater than $0 for the ten largest counties, the remainder of the state, and the state as a whole.

The amount of indemnity paid in the largest counties as a percentage of all indemnity paid tracks very closely with the counties' proportion of closed claims. Wayne, Oakland and Macomb counties account for 55 to 60 percent of the total indemnity paid each year. The total indemnity paid in the ten largest counties accounts for over 75 percent of the statewide total. Exhibit 16 shows total indemnity paid for the ten largest counties, the remainder of the state, and the state as a whole.

Allocated expenses for the largest counties also track closely with the counties' proportion of closed claims. Wayne, Oakland and Macomb counties on average account for just over 50 percent of the total allocated expenses for the state. The allocated expenses in the ten largest counties account for approximately 75 percent of the statewide total. Exhibit 17 shows total expenses for the ten largest counties, the remainder of the state and the state as a whole.

OBSTETRICAL CLAIMS

Birth-related injuries have been the focus of many efforts to develop legislation to reduce the cost of malpractice insurance in general, and the amount charged to obstetricians and gynecologists in particular. It is therefore useful to look at closed claims in this area to determine if this is a critical element in the medical malpractice "crisis." The data in this section includes all closed claims with the injury designated as "obstetrical," and claims with "misdiagnosis" and "delay in diagnosis" as the injury designation which are also showing "labor and delivery room" as the location (hereinafter referred to as OB claims).

The following table shows the total indemnity, allocated expenses and number of closed claims by year.

TABLE 9

CLOSED CLAIMS
OBSTETRICAL TOTAL INDEMNITY & EXPENSES BY YEAR

Year	Indemnity	Expenses	Claims Closed
1983	1,498,614	381,906	70
1984	999,386	224,326	32
1985	808,250	141,196	12
1986	2,863,376	596,054	37
1987	9,664,897	4,042,411	184
1988	6,058,835	1,702,860	124
Total	**21,893,358**	**7,088,753**	**459**

As the table indicates, the number of OB claims varies significantly from year to year. This should not be surprising since there are many variables -- including size of court dockets and the number, nature and complexity of cases in process -- which could determine how many claims are closed each year. However, this could be said of all malpractice actions. Therefore, it is interesting to note that, with the exception of 1988 which is not a complete year, the number of OB claims as a percentage of all closed claims is 5 percent or less each year. The total number of OB claims closed in the period from 1983 through the middle of 1988 represents 4 percent of all claims closed in those years.

EXHIBIT 15

COMPARISON OF TOTAL CLAIMS CLOSED AND CLAIMS CLOSED WITH INDEMNITY GREATER THAN $0

COUNTY		1983	1984	1985	1986	1987	1988	TOTAL
Wayne	Total Closed	717	490	897	805	1,505	794	5,208
	Closed w/Ind>$0	519	267	514	399	726	398	2,823
Oakland	Total Closed	237	170	292	264	553	294	1,810
	Ind>$0	147	95	155	141	235	124	897
Macomb	Total Closed	109	94	142	150	181	116	792
	Ind>$0	70	54	82	79	90	53	428
Genesee	Total Closed	54	42	100	78	117	92	483
	Ind>$0	40	24	46	41	57	30	238
Ingham	Total Closed	57	38	55	70	138	62	420
	Ind>$0	33	25	39	33	62	29	221
Kent	Total Closed	56	30	78	52	105	46	367
	Ind>$0	42	16	45	38	54	23	218
Washtenaw	Total Closed	40	24	63	50	126	48	351
	Ind>$0	21	8	33	30	70	24	186
Kalamazoo	Total Closed	39	19	27	31	45	31	192
	Ind>$0	27	6	21	22	19	16	111
Jackson	Total Closed	15	25	29	35	43	30	177
	Ind>$0	9	18	15	18	22	17	99
Saginaw	Total Closed	23	17	43	36	33	21	173
	Ind>$0	13	10	24	19	16	11	93
10 Co. Total	Total Closed	1,347	949	1,726	1,571	2,846	1,534	9,973
	Ind>$0	921	523	974	820	1,351	725	5,314
Remainder of State	Total Closed	393	233	451	458	740	355	2,630
	Ind>$0	260	144	248	241	381	154	1,428
Statewide	Total Closed	1,740	1,182	2,177	2,029	3,586	1,889	12,603
	Ind>$0	1,181	667	1,222	1,061	1,732	879	6,742

EXHIBIT 16

TOTAL INDEMNITY PAID

COUNTY	1983	1984	1985	1986	1987	1988	TOTAL
Wayne	14,620,929	5,233,291	24,990,303	17,311,447	41,320,905	20,104,325	123,581,200
Oakland	3,170,317	1,879,344	6,932,095	5,672,440	12,534,959	5,792,954	35,982,109
Macomb	902,522	902,832	2,212,983	2,949,763	3,377,341	2,051,262	12,396,703
Genesee	790,836	603,575	2,403,456	3,315,664	4,471,153	1,724,371	13,309,055
Ingham	1,653,358	625,204	2,538,852	2,141,142	5,399,334	1,915,920	14,273,810
Kent	589,523	657,945	2,303,967	1,689,867	2,734,236	1,851,119	9,826,657
Washtenaw	706,899	157,175	1,374,678	901,000	5,138,696	1,272,989	9,551,437
Kalamazoo	459,558	289,994	2,004,136	660,499	3,037,499	599,500	7,051,186
Jackson	199,189	281,546	1,089,558	555,300	1,049,500	1,166,009	4,341,102
Saginaw	651,885	447,400	1,086,630	358,500	1,432,231	704,050	4,680,696
10 Co. Total	23,745,016	11,078,306	46,936,658	35,555,622	80,495,854	37,182,499	234,993,955
Remainder of State	6,690,431	2,949,371	12,119,431	7,635,514	25,641,689	9,815,968	64,852,404
Statewide	30,435,447	14,027,677	59,056,089	43,191,136	106,137,543	46,998,467	299,846,359

EXHIBIT 17

ALLOCATED EXPENSES

COUNTY	1983	1984	1985	1986	1987	1988	TOTAL
Wayne	8,943,853	2,486,392	6,452,033	5,856,678	19,189,402	7,402,845	50,331,203
Oakland	2,949,955	1,122,694	2,202,908	2,345,571	10,143,119	8,283,944	27,048,191
Macomb	670,080	601,531	1,152,158	1,126,606	2,871,670	8,018,072	14,440,117
Genesee	624,585	264,158	2,936,074	3,328,009	6,606,325	985,059	14,744,210
Ingham	827,312	283,375	485,927	1,655,832	4,989,634	5,249,933	13,492,013
Kent	414,616	179,238	381,714	1,369,682	1,663,456	378,134	4,386,840
Washtenaw	416,944	77,977	407,386	227,514	1,124,690	520,412	2,774,923
Kalamazoo	482,349	142,180	278,613	838,827	1,884,928	340,341	3,967,238
Jackson	136,808	162,346	271,592	222,426	903,722	219,823	1,916,717
Saginaw	144,550	124,475	357,801	1,037,897	615,460	230,948	2,511,131
10 Co. Total	15,611,052	5,444,366	14,926,206	18,009,042	49,992,406	31,629,511	135,612,583
Remainder of State	6,222,496	1,399,641	3,518,521	5,329,648	18,599,838	9,079,046	44,149,190
Statewide	21,833,548	6,844,007	18,444,727	23,338,690	68,592,244	40,708,557	179,761,773

Again with the exception of 1988, the indemnity paid for OB claims is less than 10 percent of the total indemnity paid in a given year. The total indemnity paid for OB claims over the 5 1/2 year period being studied accounts for 7 percent of the total indemnity in that period.

Expenses related to these closed claims reflect a similar pattern, constituting 6 percent or less of allocated expenses for all closed claims each year. Allocated expenses for OB claims are consistently lower as a percentage of statewide data than indemnity.

Claims by Medicaid Recipients

There has been a commonly spoken fear among members of the health care community that Medicaid recipients are more likely to sue for medical malpractice, presumably for financial reasons. This fear, combined with the presumption that these individuals may not have sought treatment soon enough and therefore are more likely to have complications, causes doctors and hospitals to be reluctant to accept Medicaid recipients as patients.

Form B attempts to capture data on medical malpractice claims by source of medical expenses payments. The categories for this information are: (1) Medicare; (2) Medicaid; (3) Health Insurance; (4) Other (HMO, PPO, etc.); and, (5) Unknown. The table below is a compilation of closed claim data by medical expense category.

TABLE 10

CLOSED CLAIMS BY SOURCE OF MEDICAL EXPENSE PAYMENT

Year	Medicare	Medicaid	Health Insurance	Other	Unknown
1983	1	0	42	1	1,643
1984	3	1	0	0	1,157
1985	62	121	1	622	1,352
1986	73	111	61	502	1,250
1987	161	233	720	505	1,925
1988	83	120	420	211	1,030
Total	**383**	**586**	**1,244**	**1,841**	**8,357**

Clearly, no conclusions can be drawn from this data given that 67 percent of the forms which contain information in this field indicate that the source of medical expense payments is unknown and that over 5 percent of the closed claim forms did not complete this information.

PART IV

RECOMMENDATIONS

Marketplace

The Insurance Bureau would make no recommendations for changes in the marketplace at this time for several reasons. First, given the long tail for this type of liability, not enough time has passed for the effect of the 1986 tort reforms to be measured.

Further, the availability of medical malpractice insurance is better than it has been in years. Not only are there more options with regard to sources of coverage, but types and amounts of coverage as well. Also, rates are flattening, as insurers are filing fewer and considerably smaller rate increases.

The claim information reported to the Bureau does not point to any specific problem or problems as the cause of the so-called malpractice "crisis," and there is an overall trend of decreasing claim filings against all specialties.

Data Gathering

The information currently being reported to the Bureau is useful, but much could be done to improve the data base. Some of the drawbacks to the existing data stem from the reporting form having been changed several times since the reporting requirements were first instituted in 1976. Unfortunately, there are still changes which need to be made in the form to further refine our ability to evaluate the marketplace for medical malpractice insurance.

The 1986 changes in reporting requirements have further complicated our ability to use the existing data base. The receipt of multiple reports for a single claim has required manual intervention to prevent double counting of data. While the reporting form could be modified to allow for easier identification of duplicate data, the complications of reconciling the duplicate information far outweigh the possible benefits of obtaining it. Further, the only source of information over which the Bureau has enforcement authority is insurers.

Therefore, the Bureau would recommend the elimination of the reporting requirements for sources other than insurers or self-insured entities.

APPENDIX A

MICHIGAN DEPARTMENT OF LICENSING & REGULATION
INSURANCE BUREAU

FORM A
(BA-200 (6/86)

Code Sheet
Initial Report of Court or Arbitration Action

01-24 Insured's/Plaintiff's Name

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

25-30 Insured License Number

☐☐☐☐☐☐

31-37 Insured Profession and Specialty

☐☐ ☐☐☐☐☐

38-40 Other Defendants Involved

1 Yes
2 No ☐ Number ☐☐

FOR OFFICE USE ONLY
Hospital Code
47-49 ☐☐☐

41-46 Date of Incident. MM, DD, YY.

☐☐☐☐☐☐

50-55 Date Complaint Filed in Court or Arbitration. MM, DD, YY.

☐☐☐☐☐☐

56-57 Alleged Nature of Complaint

☐☐

58-59 County Code Number

☐☐

60 Court Identification

1 District
2 Circuit ☐

61-73 Court ID or Arbitration Association Number Assigned to Case.

☐☐ ☐☐☐☐☐☐☐☐☐☐☐

74-78 ☐☐☐☐☐
NAIC Company Code if known

____
Company/Attorney Name

____
Person responsible for the report

____
Phone

INSTRUCTIONS FOR COMPLETING
INITIAL REPORT OF COURT OR ARBITRATION ACTION CODE SHEET

Send completed form to: Medical Malpractice Reporting
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Insured's Name — Record last name first, space, then first name and middle initial.

Insured's License Number — This is the 5 digit number assigned to the individual by the Department of Licensing and Regulation Health Services Bureau. If hospital, leave blank.

Insured's Profession —

01 Allopathic Physician (MD)
11 Nurse
12 Dentist
13 Podiatrist
14 Osteopathic Physician (DO)
06 Chiropractor
02 Hospital (only)
05 Health Maintenance Organization
03 Professional Corporation
04 Clinic
15 Other

Insured's Specialty — Use the same code that is on the insured policy.

Dates — Record the date the incident occurred and when filed in court or for arbitration.

Alleged Nature of Complaint —

01 Anesthesia Accident
02 Blood Transfusion
03 Consent Issues
04 Delay in Diagnosis
05 Delayed/Refused Treatment
06 Equipment Failure
07 Fall
08 Medication Error
09 Misdiagnosis
10 Misidentification of Patient
11 Surgery-Technique
12 Surgery-Unnecessary
13 Treatment
14 Treatment-Unnecessary
15 Vicarious Liability
16 All Other
17 Obstetrical Procedure

County Code Number — Use list. Refers to county court where case is filed. If arbitration, leave blank.

1. Alcona
2. Alger
3. Allegan
4. Alpena
5. Antrim
6. Arenac
7. Baraga
8. Barry
9. Bay
10. Benzie
11. Berrien
12. Branch
13. Calhoun
14. Cass
15. Charlevoix
16. Cheboygan
17. Chippewa
18. Clare
19. Clinton
20. Crawford
21. Delta
22. Dickinson
23. Eaton
24. Emmet
25. Genesee
26. Gladwin
27. Gogebic
28. Grand Traverse
29. Gratiot
30. Hillsdale
31. Houghton
32. Huron
33. Ingham
34. Ionia
35. Iosco
36. Iron
37. Isabella
38. Jackson
39. Kalamazoo
40. Kalkaska
41. Kent
42. Keweenaw
43. Lake
44. Lapeer
45. Leelanau
46. Lenawee
47. Livingston
48. Luce
49. Mackinac
50. Macomb
51. Manistee
52. Marquette
53. Mason
54. Mecosta
55. Menominee
56. Midland
57. Missaukee
58. Monroe
59. Montcalm
60. Montmorency
61. Muskegon
62. Newaygo
63. Oakland
64. Oceana
65. Ogemaw
66. Ontonagon
67. Osceola
68. Oscoda
69. Otsego
70. Ottawa
71. Presque Isle
72. Roscommon
73. Saginaw
74. St. Clair
75. St. Joseph
76. Sanilac
77. Schoolcraft
78. Shiawassee
79. Tuscola
80. Van Buren
81. Washtenaw
82. Wayne
83. Wexford

* This form to be completed in compliance with Public Act 173 of 1986. Failure to complete is a violation of Section 438 of Public Act 218 of 1956, the Insurance Code.

APPENDIX A

INSTRUCTIONS FOR COMPLETING

MICHIGAN CLOSED CLAIM REPORTING FORM
FORM B

Form B
IBA-310 (8/80)

General Instructions.

Fill in the boxes completely using the appropriate number (i.e., 1 for Yes, 2 for No).

A. **IDENTIFICATION**

Defendant — Please place the hospital or defendants name and Michigan license number. Individual code numbers will be assigned by the Insurance Bureau to each hospital in the state. Use last name, first name, middle initial. Record whether the insured is the primary or secondary defendant.

Arbitration No. or Court No. & County — This is the number assigned by the Arbitration Association or Court docket number. Record the numbers as requested and in this way the Insurance Bureau will be able to cross-reference Form Bs submitted by different participating organizations for the same claim. County Codes are on the last page of this form.

Claiment's Name — Record last name first, space first name. A further cross-reference for statistical accuracy.

B. **COVERAGE**

HPL/PHY (Occurence) — Hospital Professional Liability/Physician Professional Liability — Occurence.
HPL/PHY (Claims-Made) — Hospital Professional Liability/Physician Professional Liability — Claims-Made.
HPL Self-Ins. (Occurrence) — Hospital Professional Liability Self-Insurance — Occurence.
HPL Self-Ins. (Claims-Made) — Hospital Professional Liability Self-Insurance — Claims-Made.

C. **DATES — Record by month, day, year.**

Injury — Record the date the injury first occurred.
Filing — Record the date the case was filed in court or arbitration.
Report — Record the date the participating organization first received notice of the injury as a possible claim.
Closure — Record the date the case is finally closed as far as your participating organization is concerned.

D. **INJURED PARTY**

Age — Enter the claimant's age on date of injury, if the age is months or days so indicate. Enter "UNK" if unknown.
Sex — Check as appropriate.
Type — Patient — any person on the premises for the purpose of receiving medical care.
Other — Any visitor, vendor, employees of contractors, etc.
Medical Expenses Paid By — Check as appropriate.

E. **RESOLUTION OF THIS CLAIM**

Method of Disposition — Check the appropriate method by which your claim is disposed of. If the claim is abandoned or voluntarily dismissed check "settled by parties."

F. **INJURY**

This section seeks information on the primary cause, location and severity of the injury to the patient.
Cause — Check the one cause which most nearly matches the primary reason why the claim was brought and/or paid.
Location — Check the one section which most nearly describes where the primary cause of patient's injury occurred.
Severity —
Emotional only — Fright, no physical damage.
Temporary-Insignificant — Lacerations, contusions, minor scars, rash. No delay.
Temporary-Minor — Infections, mis-set fracture, fall in hospital. Recovery delayed.
Temporary-Major — Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent-Minor — Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
Permanent-Significant — Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent-Major — Paraplegia, blindness, loss of two limbs, brain damage.
Permanent-Grave — Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
Death —

G. **INDEMNITY AND EXPENSE PAYMENTS — Round to Nearest Dollar.**

The first two lines ask for payments made by or on behalf of the organization completing this form. No attempt is made to determine the origin of the payment. Only total expense and indemnity payments are requested.
Allocated Expenses — These expenses include attorney fees, court recorder expenses, copy fees, subpoena fees, etc.
Indemnity — These are indemnity dollars paid to the claimant directly or the cost of a structured settlement. Do not enter the yield of a structured settlement. Record the amount attributable to economic and non-economic damages.
For the Entire Case — Enter the total settlement indemnity paid to claimant, including the indemnity previously reported as paid by or on behalf of this organization. If the total is unknown or the case is not completely settled enter "UNK".
Case Closed Against All Defendants — Check yes or no as appropriate.
Answer Only if Indemnity Was Paid On Behalf Of Hospital — This series of three questions is intended to determine the involvement of the staff physicians, residents and/or interns in cases involving payment on behalf of a hospital. Complete as indicated.
Answer Only If One Or More Codefendants Was Uninsured — This question is intended to determine if uninsured organizations or individuals are participating in claim settlements.

This form is to be completed in compliance with Public Act 173 of 1986. Failure to complete is a violation of Section 438 of Public Act 218 of 1956, the Insurance Code.

Send completed form to:

Medical Malpractice Reporting
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

LIST OF COUNTIES

1 ALCONA
2 ALGER
3 ALLEGAN
4 ALPENA
5 ANTRIM
6 ARENAC
7 BARAGA
8 BARRY
9 BAY
10 BENIZE
11 BERRIEN
12 BRANCH
13 CALHOUN
14 CASS
15 CHARLEVOIX
16 CHEBOYGAN
17 CHIPPEWA
18 CLARE
19 CLINTON
20 CRAWFORD
21 DELTA
22 DICKINSON
23 EATON
24 EMMET
25 GENESEE
26 GLADWIN
27 GOGEBIC
28 GRAND TRAVERSE
29 GRATIOT
30 HILLSDALE
31 HOUGHTON
32 HURON
33 INGHAM
34 IONIA
35 IOSCO
36 IRON
37 ISABELLA
38 JACKSON
39 KALAMAZOO
40 KALKASKA
41 KENT
42 KEWEENAW
43 LAKE
44 LAPEER
45 LEELANAU
46 LENAWEE
47 LIVINGSTON
48 LUCE
49 MACKINAC
50 MACOMB
51 MANISTEE
52 MARQUETTE
53 MASON
54 MECOSTA
55 MENOMINEE
56 MIDLAND
57 MISSAUKEE
58 MONROE
59 MONTCALM
60 MONTMORENCY
61 MUSKEGON
62 NEWAYGO
63 OAKLAND
64 OCEANA
65 OGEMAW
66 ONTONAGON
67 OSCEOLA
68 OSCODA
69 OTSEGO
70 OTTAWA
71 PRESQUE ISLE
72 ROSCOMMON
73 SAGINAW
74 SANILAC
75 SCHOOLCRAFT
76 SHIAWASSEE
77 ST. CLAIR
78 ST. JOSEPH
79 TUSCOLA
80 VAN BUREN
81 WASHTENAW
82 WAYNE
83 WEXFORD

APPENDIX A

CLOSED CLAIM REPORTING FORM

FORM B
IBA-210 (8/88)

NTIFICATION

INSURED'S/DEFENDANT'S NAME

LICENSE NUMBER

31 ☐
1. Primary Defendant
2. Secondary Defendant

32-36 COMPANY CODE

COURT OR ARBITRATION NUMBER

50-51 COUNTY CODE NO.

PLAINTIFF'S NAME

VERAGE

78 ☐

HPL/PHY (occurence)
HPL/PHY (claims made)
3) HPL Self-insurance (occurrence)
4) HPL Self-insurance (claims made)

ATES

2 INJURY

3 FILING

4 REPORT

00 CLOSURE

D. INJURED PARTY

101-102 AGE

103 SEX ☐
1 Male
2 Female

104 TYPE ☐
1 Patient
2 Other

105 MEDICAL EXPENSE PAID BY ☐

1) Medicare 2) Medicaid
3) Health Insurance
4) Other 5) Unknown

ESOLUTION OF THIS CLAIM

☐

) Settled by mediation
2) Settled by parties
3) Trial verdict
4) Arbitration

F. INJURY

107-108

1) Anesthesia accident
2) Blood transfusion
3) Consent issues
4) Delay in diagnosis
5) Delayed/refused treatment
6) Equipment failure
7) Fall
8) Medication error
9) Misdiagnosis
10) Misidentification of patient
11) Surgery technique
12) Surgery unnecessary
13) Treatment technique
14) Treatment unnecessary
15) Obstetrical procedure
16) Vicarious liability
17) All other

CATION

9-110 ☐☐

1) Critical care unit
2) Emergency room
3) Labor & delivery room
4) Nursery/Peds
5) Operating suite
6) Patient's room
7) Physical therapy dept.
8) Physician's office
9) Radiology
10) Recovery room
11) Special procedure room
12) Other

SEVERITY

111-112 ☐☐

1) Emotional only
2) Temp. insignificant
3) Temp. minor
4) Temp. major
5) Perm. minor
6) Perm. significant
7) Perm. major
8) Perm. grave
9) Death

INDEMNITY AND EXPENSE PAYMENTS

13-119 ☐☐☐☐☐☐☐ ALLOCATED EXPENSES: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

20-126 ☐☐☐☐☐☐☐ INDEMNITY: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

27-133 ☐☐☐☐☐☐☐ AMOUNT ATTRIBUTABLE TO ECONOMIC DAMAGES

34-140 ☐☐☐☐☐☐☐ AMOUNT ATTRIBUTABLE TO NON-ECONOMIC DAMAGES

41-147 ☐☐☐☐☐☐☐ INDEMNITY FOR ENTIRE CASE: PAID BY ALL PARTIES FOR ALL DEFENDANTS IF KNOWN

48 ☐ 1 = YES 2 = NO CASE CLOSED AGAINST ALL DEFENDANTS?

Answer only if indemnity was paid on behalf of hospital
= Yes, 2 = No

49 ☐ 1) WAS INDEMNITY PAID ON BEHALF OF THE HOSPITAL PRIMARILY THE RESULT OF ALLEGED NEGLIGENCE OF A PHYSICIAN, RESIDENT, OR INTERN?

50 ☐ IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE EMPLOYED BY THE HOSPITAL?

151 ☐ IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE COVERED UNDER THE HOSPITAL'S POLICY?

nswer only if one or more of codefendants was uninsured

52-159 ☐☐☐☐☐☐☐☐ AMOUNT PAID BY UNINSURED CODEFENDANT(S) IF KNOWN?

DATE	PERSON RESPONSIBLE FOR REPORT	TELEPHONE NUMBER

APPENDIX B

MEDICAL MALPRACTICE INSURANCE UNDER THE FEDERAL RISK RETENTION ACT

RISK RETENTION GROUPS

Anesthesiologists Professional Assurance Company
c/o Bass, Berry & Sims
First American Center
Nashville, TN 37238

National Dental Mutual Insurance Company,
A Risk Retention Group
44 Montgomery Street, Suite 1400
San Francisco, CA 94104

Ophthalonic Mutual Insurance Company,
A Risk Retention Group
c/o Potomac Insurance Managers, Inc.
Two Wisconsin Circle
Chevy Chase, MD 20815-7003

Osteopathic Mutual Insurance Company
4400 North Lincoln Boulevard
Oklahoma City, OK 73102

Physician National Risk Retention Group, Inc.
8225 Florida Boulevard, PO 46079
Baton Rouge, LA 70895

Podiatry Insurance Company of America,
Risk Retention Group, A Mutual Company
110 Westwood Place, Suite 100
Brentwood, TN 37027

Preferred Physicians Mutual Risk Retention Group
323 West 8th Street
Kansas City, MO 64105

PURCHASING GROUPS	**CARRIER**
AAPA Professional Liability Risk Purchasing Group 5100 Poplar Avenue, Suite 2100 Memphis, TN 38137	American Continental Insurance Company
The AHA/Health Care Institutions D&O Purchasing Group C/O Gerald Sullivan & Associates, Inc. 800 West Sixth Street Los Angeles, CA 90017	The Doctor's Company

Appendix B (continued)

PURCHASING GROUPS	**CARRIER**
Allied Health Purchasing Group Association 55 East Monroe St., Suite 300 Chicago, IL 60603	Chicago Insurance Co
American Assn of Oral & Maxillofacial Surgeons 9700 West Bryn Mawr Avenue Rosemont, IL 60018	St Paul Fire & Marine Insurance Co
American Dental Purchasing Group 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Internists 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Part-Time Physicians 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Physicians 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Health Care Professions Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
Associations Purchasing Group 55 East Monroe St., Suite 3300 Chicago, IL 60603	Chicago Ins Company
Health Care Center Professional Liability Group, Inc. 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians Natl Risk Retention Group
Health Care Professions Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
Health Professionals Purchasing Group Capitol Square Building Des Moines, IA 50301	RLI Insurance Co
Healthcare Purchasing Group Association 55 East Monroe St., Suite 3300 Chicago, IL 60603	Chicago Ins Company

Appendix B (continued)

PURCHASING GROUPS	**CARRIER**
Internal Medicine Purchasing Group of America 4 Embaracdero Center, 20th Floor San Francisco, CA 94111-5954	Doctor's Company
MMI Physician Interests 2275 Half Day Road, Suite 320 Bannockburn, IL 60015	American Continental Insurance Company
MI Osteopathic Risk Purchasing Group 33100 Farmington Road Farmington, MI 48024	Osteopathic Mutual Ins Co, Risk Retention Group
National Association of Orthodontists C/O Knapp, Peterson & Clarke Lawyers 70 Universal City Plaza, Suite 400 Universal City, CA 91608	National American Insurance Company
National Dental Liability Plan, Inc 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians National Risk Retention Group
National Dentists Professional Liability Insurance & Safety Group 4931 Douglas Avenue Des Moines, IA 50310	North Atlantic Casualty & Surety Insurance Company
National Indemnity Group, Inc 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians National Risk Retention Group
National Society of Dental Practitioners 1275 K Street, NW, Suite 900 Washington, D.C. 20005	Britamco Underwriters
Nationwide E.M.T. Malpractice Risk Purchasing Group, Inc 2998 Pontchatrain Drive Slidell, LA 70458	Paradigm Ins Co
Nurse-Practitioner Professional Liability Purchasing Group, Inc 151 William Street New York, NY 10038	Insurance Company State of PA
Nurses' Purchasing Group, Inc 4 Executive Park, Suite 2314 Atlanta, GA 30329	Victoria Ins Co Ltd
Nursing Organizations Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Chicago Insurance Co

Appendix B (continued)

PURCHASING GROUPS	**CARRIER**
OUM Group Medical Professional Program 11100 NE 8th Street, Suite 900 Bellevue, WA 98004	Contintental Ins Co
OUM Podiatrist Insurance Purchasing Group 11100 NE 8th Street, Suite 900 Bellevue, WA 98004	Harbor Ins Company
Osteopathic Physicians & Surgeons Professional Liability Association, Inc 1000 Savers Federal Bldg, Capitol & Spring Little Rock, AR 72201	
Osteopathic Physicians & Surgeons Professional Liability Association, Inc 101 University Avenue, Suite 100 Palo Alto, CA 94301	Clarendon National
Professional Nursing Organization Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
The National Nursing Purchasing Group Association 55 East Monroe Street, Suite 3300 Chicago, IL 60603	Chicago Ins Company
The Nursing Profession Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Chicago Ins Company

APPENDIX C

ALLOCATED EXPENSES INDEMNITY & STANDARD DEVIATION BY SEVERITY

Year	Severity	Sum Allocated Expense	Average Allocated Expense	Standard Deviation	Sum Indemnity	Average Indemnity	Standard Deviation
1983	1	467,902	7,930	30,418	274,256	4,648	8,146
	2	153,893	1,943	3,223	274,027	3,468	9,285
	3	2,069,579	4,963	10,914	2,279,702	5,466	9,186
	4	1,253,807	10,362	18,605	1,477,819	12,213	10,187
	5	3,028,181	11,828	36,308	4,850,188	18,946	44,405
	6	2,905,181	15,619	36,633	8,456,243	45,463	353,267
	7	865,526	10,428	20,469	2,168,302	26,124	42,579
	8	2,043,545	34,059	48,729	2,265,412	37,756	93,693
	9	8,950,484	19,758	105,358	14,031,841	30,975	82,289
1984	1	188,352	4,829	4,294	199,350	5,111	7,974
	2	264,780	3,951	3,720	189,032	2,821	7,678
	3	1,559,941	4,967	5,405	1,635,224	5,207	9,345
	4	596,366	6,412	5,506	1,238,892	13,321	19,635
	5	859,832	4,673	4,533	2,097,115	11,397	20,195
	6	783,700	5,892	4,976	2,984,702	22,441	32,665
	7	309,917	7,946	8,311	670,617	17,195	27,109
	8	153,643	6,680	6,085	301,836	13,123	23,032
	9	2,071,934	7,561	8,809	4,624,576	16,878	29,356
1985	1	303,085	4,392	2,767	268,904	3,897	10,514
	2	343,957	3,698	3,288	314,914	3,386	7,094
	3	3,014,616	6,400	15,025	3,355,994	7,125	16,986
	4	2,368,447	15,280	100,365	2,352,253	15,175	26,827
	5	3,149,349	8,266	19,485	6,498,860	17,049	35,380
	6	1,913,860	7,811	7,391	7,666,685	31,292	75,188
	7	1,349,785	9,710	10,110	9,609,773	69,135	109,737
	8	1,158,840	17,558	50,462	7,245,053	109,773	198,170
	9	4,500,620	8,965	9,597	20,142,264	40,124	73,966

Appendix C (continued)

ALLOCATED EXPENSES INDEMNITY & STANDARD DEVIATION BY SEVERITY

Year	Severity	Sum Allocated Expense	Average Allocated Expense	Standard Deviation	Sum Indemnity	Average Indemnity	Standard Deviation
1986	1	1,239,228	21,003	104,568	1,578,400	26,752	105,979
	2	899,276	9,991	50,690	670,451	7,449	52,745
	3	5,630,394	12,825	81,569	2,138,014	4,870	11,287
	4	945,312	5,496	5,006	2,235,651	12,997	23,976
	5	5,821,504	19,469	103,434	20,905,792	69,919	606,758
	6	1,951,129	9,611	24,619	5,041,362	24,834	45,105
	7	1,127,479	8,414	8,330	9,108,209	67,971	218,289
	8	1,253,441	24,104	83,223	3,536,999	68,019	94,285
	9	4,600,553	8,746	15,241	15,297,558	29,082	64,994
1987	1	4,634,753	48,786	383,536	363,001	3,821	8,891
	2	1,423,033	9,615	44,925	1,140,025	7,702	82,148
	3	15,375,200	22,710	125,453	28,158,239	41,592	526,957
	4	5,473,528	21,215	103,095	17,775,693	68,898	440,638
	5	10,280,834	20,317	102,834	22,301,284	44,073	452,153
	6	10,724,654	23,063	142,577	31,856,701	68,509	514,013
	7	9,107,345	33,730	210,312	23,915,891	88,577	350,778
	8	2,756,897	18,379	56,156	13,920,203	92,801	161,068
	9	19,817,713	20,993	156,487	38,263,996	40,533	154,111
1988	1	350,924	5,752	5,805	279,449	4,581	16,865
	2	542,766	5,899	6,099	369,950	4,021	14,518
	3	9,331,641	29,813	314,037	3,394,934	10,846	61,398
	4	5,118,590	40,948	292,852	2,108,831	16,870	39,555
	5	3,816,224	17,346	116,677	2,624,498	11,929	29,744
	6	2,629,181	11,381	11,322	6,333,115	27,416	48,441
	7	3,771,008	22,993	132,005	6,208,503	37,856	95,293
	8	1,297,348	15,679	21,720	5,569,646	72,333	141,912
	9	13,690,607	24,231	215,775	22,022,124	38,977	92,029

APPENDIX D

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

VIII. CLASSIFICATIONS

A. Class I

No surgery

	D.O.s	M.D.'s	
	7x230	8x230	Aerospace Medicine
	7x254	8x254	Allergy
	7x256	8x256	Dermatology
	7x240	8x240	Forensic or Legal Medicine
		8x243	Geriatrics
	7x245	8x245	Hematology - no chemotherapy, no biopsy
	7x232	8x232	Hypnosis
	7x248	8x248	Nutrition
	7x266	8x266	Pathology
	7x234	8x234	Pharmacology - clinical
	7x235	8x235	Physical Medicine, Physiatry, Manipulative Therapy or Rehabilitaton, (or not otherwise classified)
	7x231	8x231	Preventative Medicine
*		8x249	Psychiatry - no supervision, direction or performance of shock therapy
	7x250	8x250	Psychosomatic Medicine
	7x236	8x236	Public Health

* B. Class IB

No surgery

	D.O.s	M.D.'s	
*		8x239	Family Practice —
*	7x243		Geratrics
*	7x249		Psychiatry - no supervision, direction or performance of shock therapy

C. Class II

No Surgery

M.D.'s	
8x237	Diabetes
8x238	Endocrinology
8x241	Gastroenterology
8x242	General Practice
8x244	Gynecology
8x246	Infectious Diseases
8x257	Internal Medicine
8x258	Laryngology
8x259	Neoplastic Disease
8x260	Nephrology

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

C. Class II (Continued)

No Surgery

M.D.'s	
8x261	Neurology - no supervision, direction, or performance of angiography, myelography or pneumoencephalography
8x262	Nuclear Medicine
8x233	Occupational Medicine
8x114	Ophthalmology - including surgery
8x263	Opthalmology - no surgery
8x264	Otology
8x265	Otorhinolaryngology
8x268	Physicians - not otherwise classified
8x269	Pulmonary Disease
8x253	Radiology - diagnostic
8x280	Radiology - including therapeutic
8x252	Rheumatology
8X247	Rhinology

* D. Class IIB

	M.D.'s	
*	8x267	Pediatrics - no surgery

* E. Class IIIA

No Surgery

	D.O.'s	
*	7x238	Endocrinology
*	7x239	Family Practice
*	7x241	Gastroenterology
*	7x242	General Practice
*	7x244	Gynecology
*	7x257	Internal medicine
*	7x258	Laryngology
*	7x262	Nuclear Medicine
*	7x233	Occupational Medicine
*	7x263	Ophthalmology - no surgery
*	7x264	Otology
*	7x265	Otorhinolaryngology
*	7x268	Physicians - not otherwise classified
*	7x269	Pulmonary Disease
*	7x253	Radiology - diagnostic
*	7x252	Rheumatology
*	7x247	Rhinology

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BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

* F. Class III

No Surgery

D.O.'s	
7x237	Diabetes
7x246	Infectious Diseases
7x259	Neoplastic Disease
7x260	Nephrology
7x261	Neurology - No supervision, direction, or performance of angiography, myelography or pneumoencephalography
7x114	Opthalmology - including surgery
7x267	Pediatrics - no surgery
7x280	Radiology - including therapeutic

M.D.'s	
8x101	Bronchoesophagology
* 8x281	Cardiovascular Diseases - minor surgery
8x271	Diabetes - minor surgery
8x272	Endocrinology - minor surgery
8x273	Family Practice - minor surgery
8x274	Gastroenterology - minor surgery
8x275	General Practice - minor surgery
8x276	Geriatrics - minor surgery
8x277	Gynecology - minor surgery
8x278	Hematology - minor surgery
8x279	Infectious Diseases - minor surgery
8x283	Intensive Care Medicine
8x284	Internal Medicine - minor surgery
* 8x285	Laryngology - minor surgery
8x286	Neoplastic Diseases - minor surgery
8x287	Nephrology - minor surgery
8x288	Neurology - minor surgery - including shock therapy, angiography
8x290	Otology - minor surgery
8x291	Otorhinolaryngology - minor surgery
8x292	Pathology - minor surgery
8x293	Pediatrics - minor surgery
* 8x294	Physicians - minor surgery - not otherwise classified
8x270	Rhinology - minor surgery
8x115	Surgery - colon and rectal (Proctology)

* G. Class IVA

D.O.'s	
* 7x281	Cardiovascular Diseases - minor surgery
* 7x272	Endocrinology - minor surgery
* 7x273	Family Practice - minor surgery
* 7x274	Gastroenterology - minor surgery

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G. Class IVA (Continued)

	D.O.'s	
*	7x275	General Practice - minor surgery
*	7x276	Geriatrics - minor surgery
*	7x277	Gynecology - minor surgery
*	7x278	Hematology - minor surgery
*	7x283	Intensive Care Medicine
*	7x284	Internal Medicine - minor surgery
*	7x285	Laryngology - minor surgery
*	7x288	Neurology - minor surgery - including shock therapy, angiography
*	7x290	Otology - minor surgery
*	7x291	Otorhinolaryngology - minor surgery
*	7x292	Pathology - minor surgery
*	7x293	Pediatrics - minor surgery
*	7x294	Physicians - minor surgery - not otherwise classified
*	7x270	Rhinology - minor surgery

H. Class IV

D.O.'s	
7x101	Bronchoesophagology
7x271	Diabetes - minor surgery
7x279	Infectious Diseases - minor surgery
7x286	Neoplastic Diseases - minor surgery
7x287	Nephrology -minor surgery
7x115	Surgery - colon and rectal (Proctology)

M.D.'s	
8x151	Anesthesiology
8x102	Emergency Medicine - no major surgery
8x117	Surgery - general practice or family practice - not primarily engaged in major surgery -not otherwise classified
8x145	Surgery - urological

* I. Class IVB

	M.D.'s	
*	8x103	Surgery - endocrinology
*	8x104	Surgery - gastroenterology
*	8x105	Surgery - geriatrics
*	8x170	Surgery - head and neck
*	8x106	Surgery - laryngology
*	8x107	Surgery - neoplastic
*	8x108	Surgery - nephrology
*	8x158	Surgery - otology
*	8x159	Surgery - otorhinolaryngology - no plastic surgery
*	8x160	Surgery - rhinology - no plastic surgery

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J. Class V

	D.O.'s	
	7x151	Anesthesiology
	7x102	Emergency Medicine - no major surgery
	7x117	Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
	7x145	Surgery - urological

	M.D.'s	
	8x157	Emergency Medicine - including major surgery
	8x166	Surgery-abdominal
	8x143	Surgery - general - not otherwise classified
	8x169	Surgery - hand
	8x155	Surgery - otorhinolaryngology - plastic surgery
	8x156	Surgery - plastic - not otherwise classified
	8x171	Surgery - traumatic

* K. Class VB

	M.D.'s	
*	8x141	Surgery - cardiac
*	8x167	Surgery - gynecology

L. Class VI

	D.O.'s	
	7x157	Emergency Medicine - including major surgery
*	7x143	Surgery - general - not otherwise classified
*	7x167	Surgery - gynecology
	7x169	Surgery - hand
	7x159	Surgery - otorhinolaryngology - no plastic surgery
	7x155	Surgery - otorhinolaryngology- including plastic
	7x156	Surgery - plastic - not otherwise classified

	M.D.'s	
	8x168	Surgery - obstetrics
	8x153	Surgery - obstetrics and gynecology

* M. Class VIIA

	M.D's	
*	8x150	Surgery - cardiovascular
*	8x154	Surgery - orthopedic
*	8x144	Surgery - thoracic
*	8x146	Surgery - vascular

N. Class VII

	M.D.'s	
	8x152	Surgery - neurological

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PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

* O. Class VIII

(Reserved for future use.)

P. Class IX

D.O.'s	
7x168	Surgery - obstetrics
7x153	Surgery - obstetrics and gynecology
7x141	Surgery - cardiac
7x150	Surgery - cardiovascular
7x154	Surgery - orthopedic
7x144	Surgery - thoracic
7x146	Surgery - vascular
7x152	Surgery - neurological

APPENDIX D

THE
MEDICAL PROTECTIVE COMPANY
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PHYSICIANS RATE CLASSES
CLASS I

INTERNS, RESIDENTS AND FELLOWS (MOONLIGHTING ONLY).

NON-SURGICAL SPECIALTIES, TO INCLUDE: ALLERGY, CARDIOVASCULAR DISEASE, DERMATOLOGY, GASTROENTEROLOGY, INTERNAL MEDICINE, NEUROLOGY, PATHOLOGY, PSYCIATRY, PULMONARY DISEASES, RADIOLOGY.

FAMILY PRACTICE, GENERAL PRACTICE (NO SURGERY).

SURGICAL SPECIALISTS DOING NO SURGERY.

PROCEDURES NOT COVERED ON THIS CLASS:
ACUPUNCTURE,

CARDIAC CATHETERIZATION (EXCEPT SWAN-GANZ),
RADIATION THERAPY,

RADIOPAQUE DYE INJECTION DIAGNOSTIC PROCEDURES,
SHOCK THERAPY,

CLASS II

PHYSICIANS, OTHERWISE IN CLASS I, PERFORMING RADIATION THERAPY, RADIOPAQUE DYE INJECTION DIAGNOSTIC PROCEDURES, OR SHOCK THERAPY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY (NO DELIVERIE OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS.

PEDIATRICS (NO SURGERY).

CLASS III

PHYSICIANS, OTHERWISE IN CLASS I OR CLASS II, PERFORMING ACUPUNCTURE OR CARDIAC CATHETERIZATION (NOT SWAN-GANZ).

GENERAL PRACTICE OR SPECIALISTS PERFORMING MAJOR SURGERY OR ASSISTING IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS-NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

SURGICAL SPECIALISTS IN OPHTHALMOLOGY, COLON AND RECTAL SURGERY.

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Appendix D

THE
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PHYSICIANS RATE CLASSES (CONT'D)

CLASS IV

UROLOGY.
EMERGENCY MEDICINE.

GENERAL PRACTICE INCLUDING DELIVERIES.

CLASS V

SPECIALISTS IN ANESTHESIOLOGY, OR ANY PHYSICIAN ADMINISTERING GENERAL OR SPINAL ANESTHESIA, SADDLE BLOCKS, CAUDALS.

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY, GENERAL SURGERY, OTORHINOLARYNGOLOGY.

CLASS VI

SURGICAL SPECIALISTS IN PLASTIC SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, ORTHOPEDIC SURGERY, THORACIC SURGERY, TRAUMATIC SURGERY, VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY, OBSTETRICS AND/OR GYNECOLOGY.

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APPENDIX D

MICHIGAN PHYSICIANS MUTUAL LIABILITY COMPANY
Physicians and Surgeons Professional Liability

VIII. CLASSIFICATIONS

A. Class I

No Surgery

D.O.'s	M.D.'s	
7x230	8x230	Aerospace Medicine
7x254	8x254	Allergy
7x256	8x256	Dermatology
7x240	8x240	Forensic or Legal Medicine
7x245	8x245	Hematology - no chemotherapy, no biopsy
7x232	8x232	Hypnosis
7x248	8x248	Nutrition
7x266	8x266	Pathology
7x234	8x234	Pharmacology - clinical
7x235	8x235	Physical Medicine, Physiatry, Manipulative Therapy or Rehabilitation, (or not otherwise classified)
7x231	8x231	Preventive Medicine
7x250	8x250	Psychosomatic Medicine
7x236	8x236	Public Health

B. Class IB

D.O.'s	M.D.'s	
	8x239	Family Practice
7x249	8x249	Psychiatry

C. Class II

No Surgery

M.D.'s	
8x237	Diabetes
8x238	Endocrinology
8x241	Gastroenterology
8x242	General Practice
8x243	Geriatrics
8x244	Gynecology
8x246	Infectious Diseases
8x257	Internal Medicine
8x258	Laryngology
8x259	Neoplastic Disease
8x260	Nephrology
8x261	Neurology -no supervision, direction, or performance of angiography, myelography or pneumoencephalography
8x262	Nuclear Medicine
8x233	Occupational Medicine
8x114	Ophthalmology - including surgery
8x263	Ophthalmology - no surgery
8x264	Otology
8x265	Otorhinolaryngology
8x268	Physicians - not otherwise classified
8x269	Pulmonary Disease
8x253	Radiology - diagnostic
8x280	Radiology - including therapeutic

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8x252	Rheumatology
8x247	Rhinology

D. Class III

D.O.'s

7x237	Diabetes
7x238	Endocrinology
7x239	Family Practice
7x241	Gastroenterology
7x242	General Practice
7x243	Geriatrics
7x244	Gynecology
7x246	Infectious Diseases
7x257	Internal Medicine
7x258	Laryngology
7x259	Neoplastic Disease
7x260	Nephrology
7x261	Neurology - no supervision, direction, or performance of angiography, myelography or pneumoencephalography
7x262	Nuclear Medicine
7x233	Occupational Medicine
7x114	Ophthalmology - including surgery
7x263	Ophthalmology - no surgery
7x264	Otology
7x265	Otorhinolaryngology
7x268	Physicians - not otherwise classified
7x269	Pulmonary Disease
7x253	Radiology - diagnostic
7x280	Radiology - including therapeutic
7x252	Rheumatology
7x247	Rhinology

M.D.'s

8x101	Bronchoesophagology
8x281	Cardiovascular Diseases
8x271	Diabetes - minor surgery
8x272	Endocrinology - minor surgery
8x273	Family Practice - minor surgery
8x274	Gastroenterology - minor surgery
8x275	General Practice - minor surgery
8x276	Geriatrics - minor surgery
8x277	Gynecology - minor surgery
8x278	Hematology - minor surgery
8x279	Infectious Diseases - minor surgery
8x283	Intensive Care Medicine
8x284	Internal Medicine - minor surgery
8x285	Laryngology
8x286	Neoplastic Diseases - minor surgery
8x287	Nephrology - minor surgery
8x288	Neurology - minor surgery - shock therapy, angiography
8x290	Otology - minor surgery
8x291	Otorhinolaryngology - minor surgery
8x292	Pathology - minor surgery
8x267	Pediatrics
8x294	Physicians - not otherwise classifed
8x270	Rhinology - minor surgery

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8x115	Surgery - colon and rectal (Proctology)

E. Class IV

D.O.'s

7x101	Bronchoesophagology
7x281	Cardiovascular Diseases
7x271	Diabetes - minor surgery
7x272	Endocrinology - minor surgery
7x273	Family Practice - minor surgery
7x274	Gastroenterology - minor surgery
7x275	General Practice - minor surgery
7x276	Geriatrics - minor surgery
7x277	Gynecology - minor surgery
7x278	Hematology - minor surgery
7x279	Infectious Diseases - minor surgery
7x283	Intensive Care Medicine
7x284	Internal Medicine - minor surgery
7x285	Laryngology
7x286	Neoplastic Diseases - minor surgery
7x287	Nephrology - minor surgery
7x288	Neurology - minor surgery - shock therapy, angiography
7x290	Otology - minor surgery
7x291	Otorhinolaryngology - minor surgery
7x292	Pathology - minor surgery
7x267	Pediatrics
7x294	Physicians - not otherwise classifed
7x270	Rhinology - minor surgery
7x115	Surgery - colon and rectal (Proctology)

M.D.'s

8x151	Anesthesiology
8x117	Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
8x145	Surgery - urological

F. Class IVB

M.D.'s

8x102	Emergency Medicine - no major surgery

G. Class V

D.O.'s

7x151	Anesthesiology
7x117	Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
7x145	Surgery - urological

M.D.'s

8x157	Emergency Medicine - including major surgery
8x166	Surgery - abdominal
8x103	Surgery - endocrinology
8x104	Surgery - gastroenterology
8x143	Surgery - general - not otherwise classified
8x105	Surgery - geriatrics
8x169	Surgery - hand

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8x170 Surgery - head and neck
8x106 Surgery - laryngology
8x107 Surgery - neoplastic
8x108 Surgery - nephrology
8x158 Surgery - otology
8x159 Surgery - otorhinolaryngology - no plastic surgery
8x155 Surgery - otorhinolaryngology - plastic surgery
8x156 Surgery - plastic - not otherwise classified
8x160 Surgery - rhinology - not plastic surgery
8x171 Surgery - traumatic

H. Class VB

D.O.'s
7x102 Emergency Medicine - no major surgery

I. Class VIA

M.D.'s
8x167 Surgery - Gynecology

J. Class VI

D.O.'s
7x157 Emergency Medicine - including major surgery
7x169 Surgery - hand
7x159 Surgery - otorhinolaryngology - no plastic surgery
7x155 Surgery - otorhinolaryngology - including plastic
7x156 Surgery - plastic - not otherwise classified

M.D.'s
8x168 Surgery - obstetrics
8x153 Surgery - obstetrics and gynecology

K. Class VII

M.D.'s
8x141 Surgery - cardiac
8x150 Surgery - cardiovascular
8x154 Surgery - orthopedic
8x144 Surgery - thoracic
8x146 Surgery - vascular

L. Class VIII

D.O.'s
7x143 Surgery - general - not otherwise classified

M.D.'s
8x152 Surgery - neurological

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M. Class VIIIB

D.O.'s

7x167	Surgery - Gynecology

N. Class IX

D.O.'s

7x168	Surgery - obstetrics
7x153	Surgery - obstetrics and gynecology
7x141	Surgery - cardiac
7x150	Surgery - cardiovascular
7x154	Surgery - orthopedic
7x144	Surgery - thoracic
7x146	Surgery - vascular
7x152	Surgery - neurological

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II. RISK CLASSIFICATIONS

NOTE: When two or more classifications apply, use the highest-rated classification.

A. Allopathic (M.D.) and Osteopathic (D.O.) Physicians and Surgeons

CLASS 1 - Basic care/no surgery (no obstetrical procedures or surgery other than the incision of boils and superficial abscesses or suturing of skin and superficial fascia).

M.D. CODE	D.O. CODE	
80230		Aerospace Medicine - The branch of medicine which deals with the physiological, medical, psychological and epidemiological (i.e. disease-related) problems in present day air and space travel.
80254	84254	Allergy - A condition in which an individual is sensitive to a substance (or temperature) that does not affect most other people—such as pollen, dust or food.
80256	84256	Dermatology - The branch of medicine that deals with diagnosis and treatment of diseases of the skin. (Not including hair transplants - See Class 3).
80240	84240	Forensic/Legal Medicine - The application of medical principles in Law. (Autopsies)
80231		General Preventive Medicine - The branch of medicine which aims at the prevention of disease.
80243	84243	Geriatrics - The branch of medicine that deals with the structural changes, physiology, diseases and hygiene of old age.
80245	84245	Hematology - The branch of medicine that deals with the blood and its diseases.
80232		Hypnosis - A trance-like condition that can be artificially induced, characterized by an altered consciousness, diminished willpower, and an increased responsiveness to suggestion.

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CLASS 1 - Basic care/no surgery (continued)

M.D. CODE	D.O. CODE	
80248		**Nutrition** - The branch of medicine that deals with the act or process of nourishing or taking nourishment, especially the process by which food is assimilated.
80266	84266	**Pathology** - The branch of medicine that deals with the origin, nature, causes and development of diseases.
80234		**Pharmacology - clinical** - The branch of medicine concerned with the nature, preparation, administration and effects of drugs.
80235	84235	**Physiatry/Physical Medicine/Rehabilitation** - **Physiatry** - The practice of Physical Medicine. **Physical Medicine** - A consultative, diagnostic, therapeutic medical specialty coordinating and integrating the use of physical therapy (use of light, heat, cold, water, electricity, and exercises) occupational therapy and physical reconditioning in the professional management of the diseased and injured.
80249	84249	**Psychiatry - including child** - The branch of medicine that deals with the diagnosis, treatment and prevention of mental disorders.
80250		**Psychoanalysis** - A system used in the treatment of nervous and mental disorders.
80251	84251	**Psychosomatic Medicine** -The branch of medicine that investigates the reciprocal influences of body and mind in the cause, prevention, treatment and cure of disease.
80236		**Public Health** - The branch of medicine that deals with the protection and improvement of community health by organized community effort and including preventive medicine and sanitary and social science.

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CLASS 2 - Life systems/no surgery (no obstetrical procedures or surgery other than incision of boils and superficial abscesses or suturing of skin and superficial fascia)

M.D. CODE	D.O. CODE	
80237		**Diabetes** - The branch of medicine that deals with a disease associated with deficient insulin secretion.
80238	84238	**Endocrinology** - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.
80420	84420	**Family Physicians/General Practitioners** - **Family Physicians** - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; **General Practitioners** - The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or the condition that may temporarily require the services of a specialist. (Not including prenatal - See Class 3).
80239	84239	**Family Physicians (old)**
80241	84241	**Gastroenterology** - The branch of medicine that deals with anatomy, physiology and pathology of the stomach and intestines.
.....	.....	**General Practitioners (new)** - See FP/GP Code XX420
80242	84242	**General Practitioners (old)**
80244	84244	**Gynecology** - The branch of medicine that deals with the functions and diseases of women.
80246		**Infectious Diseases** - Any diseases that are due to the growth and action of microorganisms or parasites in the body, and that may or may not be contagious.
80257	84257	**Internal Medicine** - The branch of medicine that is concerned with diseases of the internal organs.

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CLASS 2 - Life Systems/no surgery (Continued)

M.D. CODE	D.O. CODE	
80258		**Laryngology** - The branch of medicine that deals with the larynx (throat part, vocal cords), its functions and its pathology.
80259		**Neoplastic Diseases** - Any diseases that are concerned with any new and abnormal growth, such as a tumor.
80260		**Nephrology** - The branch of medicine that deals with the kidney and its diseases.
80261		**Neurology - including child** - The branch of medicine that deals with the nervous system and its disorders.
80262	84262	**Nuclear Medicine** - The branch of medicine that deals with diagnostic, therapeutic and investigative use of radioactive materials.
80233	84233	**Occupational Medicine** - The branch of medicine that deals with treatment of work related illnesses and injuries.
.....	.....	**Oncology** - The sum of knowledge concerning tumors, the study of tumors; (Use Physicians - N.O.C. Code XX268)
80263	84263	**Ophthalmology** - The branch of medicine that deals with the structure, functions and diseases of the eye.
80289	84289	**Ophthalmology - minor surgery**
80114		**Ophthalmology - surgery**
80264		**Otology** - The branch of medicine that deals with the ear and its diseases.
80265	84265	**Otorhinolaryngology** - The branch of medicine that treats the ear, nose and throat.
80268	84268	**Physicians - N.O.C.** - Not otherwise classified.
80269	84269	**Pulmonary Disease** - Any diseases that are affecting the lungs.

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CLASS 2 - Life Systems/no surgery (Continued)

M.D. CODE	D.O. CODE	
80253	84253	Radiology - diagnostic - The branch of medicine that relates to radiant energy and its application especially in the diagnosis and treatment of disease.
80252	84252	Rheumatology - The branch of medicine that treats rheumatism, a disease marked by inflammation of the connective tissue structures of the body, especially the muscles and joints.
80247		Rhinology - The branch of medicine that relates to the nose and its diseases.

CLASS 2A - Pediatrics/no surgery

M.D. CODE	D.O. CODE	
80267	84267	Pediatrics - The branch of medicine that deals with the diseases and hygienic care of children.

CLASS 3 - Minor surgery /assisting in major surgery on own patients

NOTE: Also includes emergency room work up to 16 hours per week.

M.D. CODE	D.O. CODE	
80255	84255	Cardiovascular Disease - no surgery - Any diseases that are pertaining to the heart and blood vessels.
80281	84281	Cardiovascular Disease - Including arterial, cardiac, or diagnostic catheterization.
80282	84282	Dermatology - The branch of medicine that deals with diagnosis and treatment of diseases of the skin (including hair transplants).
80271		Diabetes - The branch of medicine that deals with a disease associated with deficient insulin secretion.

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CLASS 3 - Minor surgery/assisting in major surgery on own patients
(continued)

M.D. CODE	D.O. CODE	
80272	84272	**Endocrinology** - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.
80421	84421	**Family Physicians/General Practitioners** - **Family Physicians** - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; **General Practioners** - The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or of the condition that may temporarily require the services of a specialist (including prenatal care and normal vaginal deliveries).
80273	84273	**Family Physicians (old)**
80274	84274	**Gastroenterology** - The branch of medicine that deals with the anatomy, physiology and pathology of the stomach and intestines.
80276	84276	**Geriatrics** - The branch of medicine that deals with the structural changes, physiology, diseases and hygiene of old age.
80277	84277	**Gynecology** - The branch of medicine that deals with the functions and diseases of women.
80278	84278	**Hematology** - The branch of medicine that deals with the blood and its diseases.
80279		**Infectious Disease** - Any diseases that are due to the growth and action of microorganisms or parasites in the body, and that may or may not be contagious.
80283	84283	**Intensive Care Medicine/Pulmonary Critical Care** - This classification applies to any general practitioner or specialists employed in an intensive care hospital unit. **Pulmonary Critical Care** - Intensivist specializing in pulmonary medicine.

LANSING, MICHIGAN

CLASS 3 - Minor surgery/assisting in major surgery on own patients
(continued)

M.D. CODE	D.O. CODE	
80284	84284	Internal Medicine - The branch of medicine that is concerned with diseases of the internal organs.
80285		Laryngology - The branch of medicine that deals with the larynx (throat part, vocal cords), its functions and its pathology.
	84801	Manipulator - Skillful handling in the adjustment of an abnormality or the bringing about of a desirable condition as the changing of the position of the fetus, the alignment of the fragments of a broken bone, the replacement of a protruding organ (hernia), etc.
80286		Neoplastic Diseases - Any diseases that are concerned with any new and abnormal growth, such as a tumor.
80287		Nephrology - The branch of medicine that deals with the kidney and its diseases.
80288	84288	Neurology - including child - The branch of medicine that deals with the nervous system and its disorders.
80290		Otology - The branch of medicine that deals with the ear and its diseases.
80291	84291	Otorhinolaryngology - The branch of medicine that treats the ear, nose and throat.
80292	84292	Pathology - The branch of medicine that deals with the origin, nature, causes and development of diseases.
80293	84293	Pediatrics - The branch of medicine that deals with the diseases and hygienic care of children.
80533	84533	Physicians - N.O.C. - Not otherwise classified.
.....	.....	Pulmonary Critical Care - See Intensive Care Medicine - Use Code XX283

JUL - 1 1992
MICHIGAN

CLASS 3 - Minor surgery/assisting in major surgery on own patients (continued)

M.D. CODE	D.O. CODE	
80280	84280	Radiology - diagnostic - The branch of medicine that relates to radiant energy and its application especially in the diagnosis and treatment of disease.
80270		Rhinology - The branch of medicine that relates to the nose and its diseases.
	84802	Sclerotherapy - The use of a chemical irritant (a sclerosant) to produce a hardening of a structure, as by injecting it into a varicose vein. Sclerosant - a medicinal substance which induces inflammation in a tissue and a subsequent hardening or shrinkage.

CLASS 4 - Special Care and Surgery

M.D. CODE	D.O. CODE	
80101		Bronchoesophagology - The branch of medicine which deals with the bronchial tree (body tubes which carry air) and the esophagus (muscular tubular organ which carries food from mouth to stomach).
80115		Colon & Rectal surgery - Surgery pertaining to the colon and rectum.
80102	84102	Emergency Medicine - no major surgery - This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility who does not perform major surgery.
80103		Endocrinology - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.

JUL -1 1990

LANSING, MICHIGAN

CLASS 4 - Special Care and Surgery

M.D. CODE	D.O. CODE	
80117	84117	**Family Physicians/General Practitioners** - **Family Physician** - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; **General Practitioner** The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or of the condition that may temporarily require the services of a specialist (including tonsillectomies and adenoidectomies).
80104		**Gastroenterology** - The branch of medicine that deals with the anatomy, physiology and pathology of the stomach and intestines.
80105		**Geriatrics** - The branch of medicine that deals with the structural changes, physiology, diseases and hygiene of old age.
80170		**Head and Neck Surgery** - Surgery of the head and neck.
80106		**Laryngology** - The branch of medicine that deals with the larynx (throat parts, vocal cords), its functions and its pathology.
80107		**Neoplastic Disease** - Any diseases that are concerned with any new and abnormal growths such as a tumor.
80108		**Nephrology** - The branch of medicine that deals with the kidney and its diseases.
80158		**Otology Surgery** - The branch of medicine that deals with the ear and its diseases.
80159		**Otorhinolaryngology Surgery** - The branch of medicine that treats the ear, nose and throat.
80534	84534	**Physicians - N.O.C.** - Not otherwise classified.

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LANSING, MICHIGAN

CLASS 4 - Special Care and Surgery (Continued)

M.D. CODE	D.O. CODE	
80160		Rhinology Surgery - The branch of medicine that relates to the nose and its diseases.
80145	84145	Urology - The branch of medicine pertaining to the urinary tract of both male and female, and with the genital organs of the male.

CLASS 5 - Anesthesiology

M.D. CODE	D.O. CODE	
80151	84151	Anesthesiology - The branch of medicine specializing in anesthesia-the abolition of sensation or the rendering unconscious by artificial means.

CLASS 6 - Major Surgery

M.D. CODE	D.O. CODE	
80166		Abdominal Surgery - Surgery of the abdominal viscera.
80141		Cardiac Surgery - Surgery of the heart.
80157	84157	Emergency Medicine - major surgery - This classification applies to any general practitioner of specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility who performs major surgery.
80143	84143	General Surgery - N.O.C. - That which deals with surgical problems of all kinds.
80167	84167	Gynecology Surgery - Surgery pertaining to the functions and diseases of women.
80169		Hand Surgery - Surgery of the hand.
80156	84156	Plastic Surgery - N.O.C. - Surgery concerned with the restoration of body structures that are defective or damaged by injury or disease.

INSURANCE BUREAU RECEIVED JUL - 1 1988 LANSING, MICHIGAN

5 - **Major Surgery** (continued)

M.D. CODE	D.O. CODE	
80155	84155	**Plastic/Otorhinolaryngology Surgery** - Surgery pertaining to the restoration or reconstruction of body structures, ear, nose or throat.
80171		**Traumatic Surgery** - Surgery pertaining to trauma (e.g. a wound or injury).

- Reserved for future use

- Critical care and surgery

M.D. CODE	D.O. CODE	
80150	84150	**Cardiovascular Disease Surgery** - Surgery pertaining to the heart and blood vessels.
80153	84153	**Obstetrics/Gynecology Surgery** - Surgery pertaining to obstetrics and gynecology.
80168		**Obstetrical Surgery** - Surgery pertaining to pregnancy and childbirth.
80154	84154	**Orthopedic Surgery** - The branch of surgery concerned with the preservation and restoration of the function of the skeletal system.
80144	84144	**Thoracic Surgery** - Surgery pertaining to the chest.
80146		**Vascular Surgery** - Surgery of the blood vessels within the limbs of the body, or the trunk, neck, abdomen or head.

A - **Neurosurgery - including child**

M.D. CODE	D.O. CODE	
80152	84152	**Neurosurgery - including child** - Surgery pertaining to the nervous system.

RECEIVED
JUL - 1 1988
LANSING, MICHIGAN

June 21, 1989.

Dear Senator Riegle:

I would certainly like to be present for the Subcommittee hearing on health care for the uninsured, but staffing shortages at my place of employment make this impossible. Having worked in health care for the last twenty years I have seen tremendous changes in reimbursement to hospitals and the affect this has had on their ability to provide quality health care.

Hospitals at the present time are doing a delicate balancing act; attempting to provide good care to all who need it while at the same time trying to balance the budget so they may retain and attract qualified individuals to provide this care. As as labor intensive business hospitals must be able to provide competitive wages and benefits if they are to maintain staffing to provide health care services to the community. Inner city hospitals particularly those that embrace the mission of caring for the indigent find the financial burden of recent reimbursement changes even more difficult. Thirty seven million Americans at the present time are medically uninsured; how can we justify this in a country of such great wealth? The aged population of our country is also increasing and it is estimated that the number of people over the age of 65 needing nursing care will increase 64% between 1908 and 2000. At the present time 40% of all medicaid costs now go to pay for nursing home care for the elderly. Compound this idea with the results of a survey of Michigan Hospitals showing that hospitals had a loss of 18 cents on each dollar of care provided to Medicaid patients.

We must address the issue of health care for the needy, before hospitals can no longer stand the financial strain of decreased reimbursement with the community expecting the same high quality health to which it has become accustomed. Perhaps an additional tax on any consumer product that has adverse health risks would be a good place to start. The community can no longer expect to have quality health care without some type of personal responsibility for it's funding.

I have enclosed two articles that seemed pertinent to the hearing. I applaude your efforts to address an issue that is so important to all Americans.

Sincerely,

Karen Moore

Karen Moore CRNA, MS

Negative margins to hurt access to capital

By Jay Greene

Net operating margins at the nation's hospitals are expected to dip below 0% in 1990, marking the first time since 1979 that hospitals will average a deficit on patient operations.

Although hospitals are expected to maintain a positive total margin through the 1990s, declining operating profits mean more hospitals will be unable to raise money through the capital markets, forcing them to delay improvements and equipment purchases or seek merger partners, healthcare experts said.

Early losses. From 1964 to 1975, net hospital operating margins averaged −3.5%. By the late 1970s, operating margins had improved steadily toward the break-even mark, reaching a high of 1.9% in 1984, according to the American Hospital Assn.'s National Hospital Panel Survey.

"Operating margins improved in the 1970s because hospitals realized the financial markets required better margins to raise capital," said Richard Clarke, president of the Healthcare Financial Management Assn., Westchester, Ill.

In addition, many hospitals participated in cost-containment programs in the 1970s, Mr. Clarke said. Those programs were requested by the federal government, which was becoming concerned by the explosive growth in Medicare expenditures.

"Hospitals cut expenses to increase their margins," Mr. Clarke said. "It's not that easy anymore."

In 1984, average operating margins increased to almost 2% primarily because of favorable Medicare payments in the second year of the prospective pricing system. Since then, however, increases in Medicare payment rates have lagged behind the rate of increase in hospitals' costs, trimming hospitals' margins, experts said.

Because hospitals also are receiving less money from private payers, average net patient margins again will dip below 0%, ranging from −3% to −4% in the 1990s, said Henry Bachofer, vice president and director of the AHA's Office of Health Care Financing and Data Analysis.

Hard times. Healthcare experts say hospitals that lose money on operations are having a more difficult time doing business today, compared with 20 years ago when markets were expanding.

From the late 1940s through the early 1970s, hospitals derived most of their funding for construction and technology from federal Hill-Burton Act construction grants and charitable contributions.

But the government ended Hill-Burton funding in 1974 after spending billions of dollars at some 4,600 hospitals. Mr. Clarke said charitable contributions, which could be used for capital expenses, have decreased as a percentage of gross revenues, especially at community hospitals. However, specific figures on that decline weren't available.

In addition, hospitals that expanded inpatient operations in the last 10 years now are looking for funds to build outpatient clinics to meet changing patient demands, said Terence Mieling, national healthcare director with John Nuveen & Co., a Chicago-based investment banking firm.

"Access to capital is one of several problems hospitals under 200 beds face," Mr. Mieling said. Other problems include lack of utilization, rising expenses and a reduction in what Medicare pays for capital expenses, he said.

In the late 1990s, average total net margins—which include income from non-patient operations—may drop to about 3.6% from the 4.8% margin recorded in 1988, said Mr. Bachofer, who based his estimate on statistical trends.

That will discourage lenders from investing in hospitals, Mr. Mieling said. "Investor confidence in hospitals is at an all-time low," he said.

Mr. Mieling said lenders base a hospital's creditworthiness more on its operating margin than on its total margin. "A good operating margin gives lenders confidence in the ability of a hospital to repay its debt, even if it has a bad year," he said.

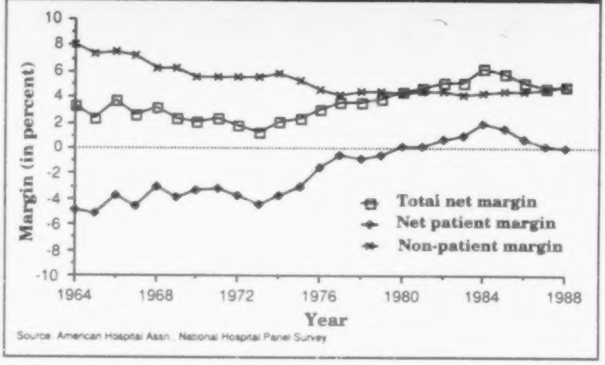
Capital expense ratio. In HFMA's annual survey of about 1,400 hospitals, their average capital expense ratio—which measures what percentage of a facility's operating expenses goes to capital improvements—increased to 9.1% of total operating expenses in 1987 from 7.3% in 1985.

"As hospitals treat sicker patients, more expensive technology is required," Mr. Clarke said.

Another disturbing statistic is the gradual erosion of hospitals' average debt service coverage ratio, which measures the ability of hospitals to repay debt. From 1981 to 1987, hospitals' average debt service coverage ratio—the ratio of available funds for debt service payment to that year's principal and interest—slipped to 2.938 from 3.265, Mr. Clarke said.

"Where are hospitals going to get their money for renovation and equipment if the investors are scared off by poor margins?" Mr. Clarke asked. "We may need the government to intervene to help hospitals obtain access to capital." ■

Profit margins in community hospitals 1964-1988



Source: American Hospital Assn., National Hospital Panel Survey

Survey: Hospitals shorted 18 cents on the dollar

by William Lubaway and Norman Bandemer

The perception that Michigan hospitals were being underpaid by Medicaid was verified in a recent study that showed a loss of 18 cents on each dollar of care provided to Medicaid patients.

The study, conducted by the Healthcare Financial Management Association, Michigan chapters, and the accounting and consulting firm of Coopers & Lybrand, documents hospitals' actual costs compared to the amount of reimbursement received from the Medicaid program. Simply, the survey put a price tag on Medicaid underpayments.

According to Ronald Kovener, vice president with the HFMA's Washington, DC, office, "Medicaid's definition of cost excludes many important factors such as the effect of inflation. Someone must cover these costs if Michigan hospitals are to continue to provide the care Michigan citizens expect."

Cost shifting sometimes the only alternative

The survey work also highlights the fact that the net result of the Medicaid shortfall threatens the financial viability of those hospitals that provide the majority of services to Medicaid recipients and increases the cost of health care to the private sector through cost shifts.

According to some CFOs from hospitals in the south central and southeast districts of the state, cost-shifting is a reality. According to one, "Although our hospital will continue to treat Medicaid patients, the Medicaid underpayment we are absorbing is putting undue pressure on the patients who pay their share of the costs they receive. The only way we can continue to care for Medicaid patients is to raise our prices to those who pay full charges. Call this cost shifting or call it a hidden tax, but we don't have any alternative."

A CFO from a hospital in the Upper Peninsula District concurs. "If reimbursement rates are not increased, it is going to increase the financial burden of the community. Our hospital is one of the county's largest employers, and we have effectively and efficiently reduced costs. We can't print money to pay our bills let alone pay for increases in malpractice and other normal inflationary costs. Our employees, patients, and their families will suffer."

Donald Potter, president of the Southeast Michigan Hospital Council, questioned the legality of underpayment after reviewing the survey results. "What other state vendors would consistently accept less than their costs for services they provide? Hospitals have to treat whoever shows up at the door, regardless of their ability to pay. When those are Medicaid patients, the hospitals lose.

Figure 1
Percentage of Medicaid Total Costs Reimbursed

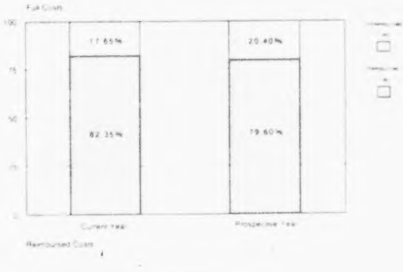


Figure 2
Percentage of Medicaid Inpatient Costs Reimbursed
by the Medicaid Program

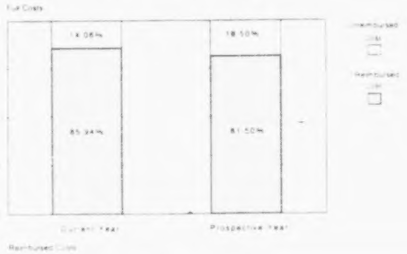


Figure 3
Percentage of Medicaid Outpatient Costs Reimbursed
by Medicaid Program

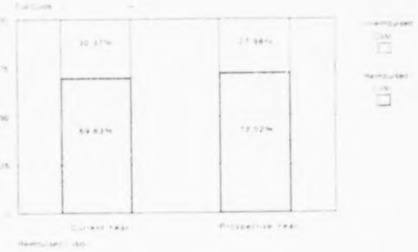


Figure 4
Medicaid Inpatient Underpayment per Discharge

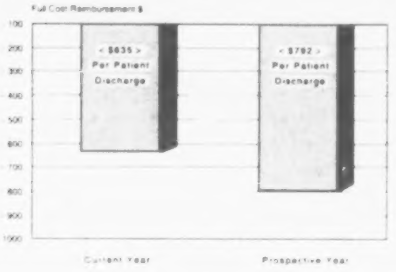
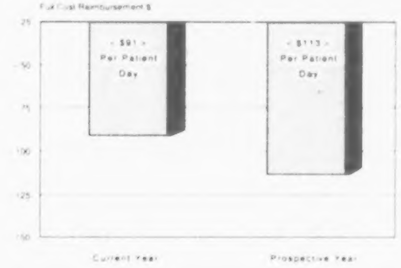


Figure 5
Medicaid Inpatient Underpayment by Patient Day



The survey document and an input computer disk were developed by Coopers & Lybrand and Bill Lubaway, chief financial officer of Mercy Hospitals and Health Services of Detroit. The survey and disk were sent in August to the 196 chief financial officers of Michigan hospitals. Of that total 53 (27 percent), provided responses by the deadline of October 31, 1988. Seventy-two percent of the top 25 Medicaid-utilized hospitals in the state participated in the survey.

The hospitals were asked to compute their costs of providing inpatient and outpatient services to the Medicaid program's eligible recipients at their hospitals. The formula used was similar to the one used by hospitals to compute their total costs of serving Blue Cross and Blue Shield of Michigan patients. This gives recognition to the cost of uncompensated care, hospital-based physician related costs, and a pro rata share of professional liability insurance.

The hospitals were then asked to compare the Medicaid costs derived from this formula to the amount of Medicaid reimbursement they received from the state of Michigan and to identify the excess or shortfall. The survey identified on a specific hospital basis a Medicaid over or under payment of costs in total as well as, on an inpatient and outpatient basis, on a per discharge and a per patient day basis. The survey requested other key information such as utilization, cost-to-charge ratios, and percentage of bad debt expense. The hospitals were also asked to estimate their costs for next year in an effort to determine prospectively what excesses or shortfalls from Medicaid could be expected. Of the 53 hospitals that responded, 42 submitted prospective data.

The hospitals reported their data both currently and prospectively on the basis of the hospitals' individual fiscal years. Therefore, the current year data were for fiscal year ends occurring from September 30, 1987, through June 30, 1988, and prospective year data for fiscal year ends from

Figure 6
Percentage of Medicaid Utilization of Services

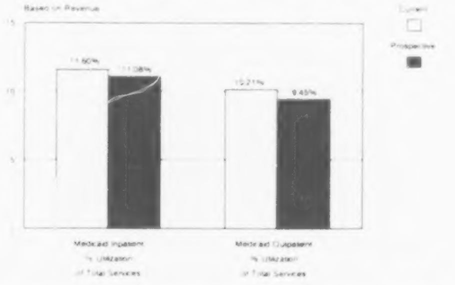


Figure 7
Ranking of Medicaid Inpatient Ancillary
Percent Utilization

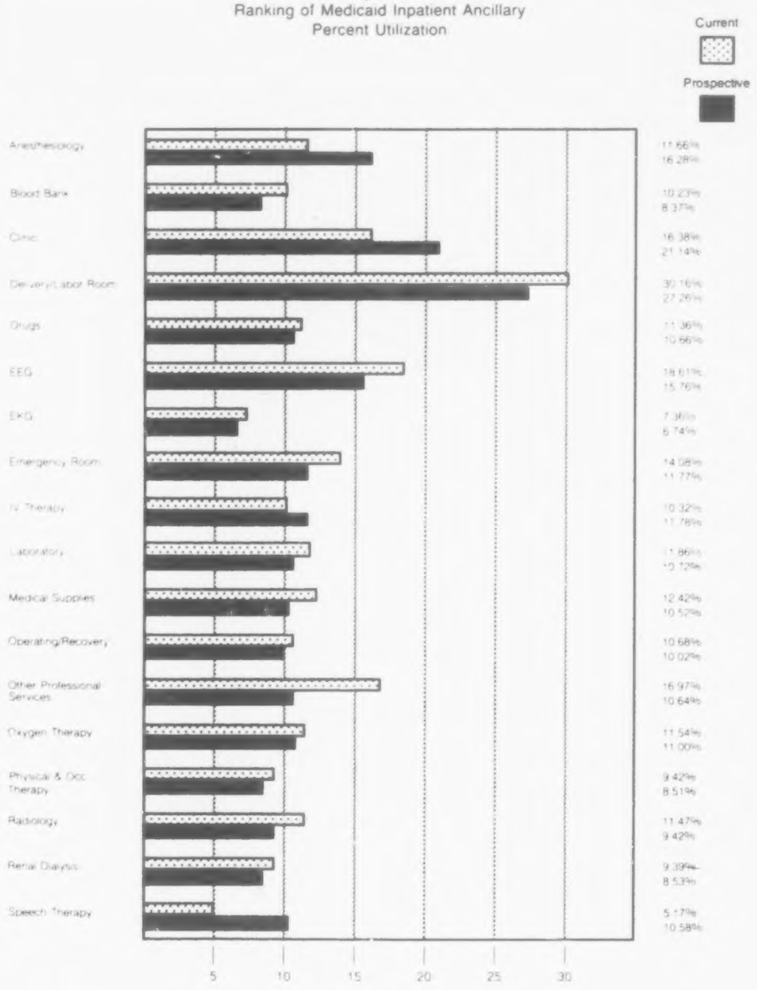
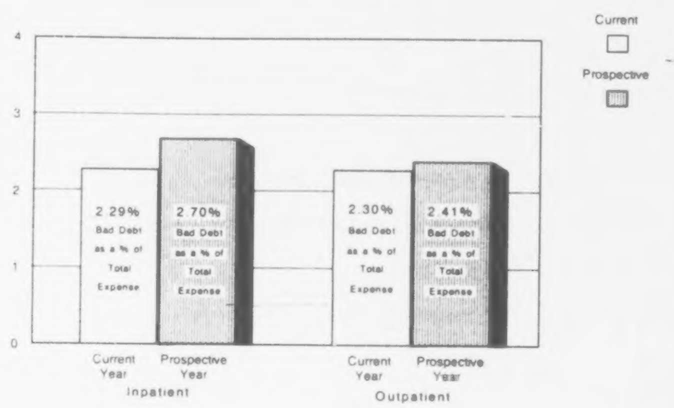


Figure 9
Bad Debt Expense as a Percentage of Total Expense



September 30, 1988, through June 30, 1989.

This Survey of Medicaid Payments to Michigan Hospitals illustrates the problems facing hospital administration and executive boards across the state and should encourage open dialogue with elected state officials. Copies of the complete HFMA/Coopers & Lybrand Michigan Hospitals' Medicaid Costs vs. Reimbursement Survey Results may be obtained by contacting Coopers & Lybrand Healthcare Services Group at 400 Renaissance Center, Detroit, Michigan 48243, (313) 446-7410. ☐

William Lubaway is chief financial officer for Mercy Hospitals and Health Services of Detroit. Norman Bandemer is regional director for Health Care Financial Consulting with Coopers & Lybrand, Detroit.

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Regards Health Care:

I feel that We need to go to the Kind Of Health Care that Canada Has Because the Cost of Health Care thru any Insurance Company is far Out of Line for What they Paid. The Hospital + Doctors Has a Price than the Insurance B/C B/S Has there Price of what they Paid. When it requires that Radiology Consultants are needed they Don't Paid, The Same when a Annesthesiology is needed the Insurance Company Don't Paid for it. According to the Free Press Sunday edition 7/2/[illegible] The Three auto Makers are Looking At Canada for the Insurance. I feel that its time that We Look At National Insurance for everybody. & that the Doctor & Hospital accepted the Payment that National Insurance Paid as the full amount.

Sincerely
Richard Marcarelli

1000 Harrington Boulevard
Mount Clemens, Michigan 48043
Telephone (313) 466-8090

MOUNT CLEMENS GENERAL HOSPITAL

JUNE 23, 1989

SENATOR DONALD W. RIEGLE, JR.
1850 MCNAMARA FEDERAL BLDG.
477 MICHIGAN AVE.
DETROIT, MI 48226

DEAR SENATOR,

WE THANK YOU FOR THE OPPORTUNITY TO PRESENT TO YOUR SUBCOMMITTEE ON HEALTH, OUR PERSPECTIVE ON THE UNINSURED ISSUE.

THE MICHIGAN SOCIAL WELFARE ACT MANDATES THAT COUNTY GOVERNMENTS PROVIDE FOR THE NECESSARY HOSPITALIZATION OF MEDICALLY INDIGENT PATIENTS. ADDITIONALLY, COUNTY BOARDS OF COMMISSIONERS ARE REQUIRED TO MAKE SUFFICIENT APPROPRIATIONS NECESSARY TO PAY FOR THE INPATIENT CARE OF MEDICALLY INDIGENT PATIENTS. REGRETTABLY, COUNTY GOVERNMENTS HAVE NOT LIVED UP TO THIS RESPONSIBILITY, STATING LACK OF MONEY AND THE HEADLEE AMENDMENT TO THE STATE CONSTITUTION AS THEIR REASONS FOR NOT PROVIDING FOR THE CARE OF INDIGENTS. THE HEADLEE AMENDMENT DOES PREVENT THE STATE FROM MANDATING GREATER EXPENDITURES OF FUNDS BY COUNTIES OR REQUIRING ADDITIONAL CATEGORIES OF INDIVIDUALS BE COVERED UNDER THE RESIDENT COUNTY HOSPITALIZATION (RCH) PROGRAM. HOWEVER, THE MICHIGAN ATTORNEY GENERAL (1982) OPINED THAT THE CURRENT OBLIGATIONS OF COUNTIES TO PROVIDE FOR MEDICALLY INDIGENT PATIENTS' HOSPITALIZATION IS NOT AFFECTED BY THE HEADLEE AMENDMENT. THEREFORE, HOSPITALS NEED TO ADVOCATE FOR COUNTY GOVERNMENTS TO FULFILL THEIR RESPONSIBILITIES AS IT RELATES TO THE HOSPITALIZATION OF MEDICALLY INDIGENT PATIENTS. IF COUNTIES ARE UNABLE TO MEET THE OBLIGATIONS OF THE SOCIAL WELFARE ACT, THEN SERIOUS CONSIDERATION SHOULD BE GIVEN TO THE DEVELOPMENT OF A HEALTH POLICY AS IT REGARDS CARE PROVIDED TO INDIGENTS.

BACKGROUND

SINCE 1987 SELECT LOW INCOME INDICATORS SUCH AS GENERAL ASSISTANCE, AID TO DEPENDENT CHILDREN, MEDICAID, AND THE FOOD STAMP PROGRAM HAVE ALL SHOWN A SUBSTANTIAL DECREASE IN THE NUMBER OF PERSONS ENROLLED (TABLE 1 AND 2). AT THE SAME TIME 14.5% OF MICHIGAN`S POPULATION WERE IN POVERTY IN 1987 OR ABOUT 661,078 PERSONS IN SOUTHEASTERN MICHIGAN. FURTHERMORE, DURING THIS SAME PERIOD SOUTHEASTERN MICHIGAN HOSPITALS SAW THEIR UNCOMPENSATED CARE INCREASE FROM $140 MILLION IN 1985 TO $196 MILLION IN 1987 (SEE FIGURE 1). WHILE UNCOMPENSATED CARE INCREASED BY $56 MILLION IN A TWO YEAR PERIOD OF TIME (1985-87), COUNTY EXPENDITURES FOR RCH DECLINED BY MORE THAN $3.8 MILLION IN JUST A ONE YEAR PERIOD OF TIME, 1986-1987 (SEE TABLE 3). RCH PATIENT DAYS ALSO INCREASED DURING THIS TIME WHICH MEANS SOUTHEASTERN MICHIGAN HOSPITALS PROVIDED MORE CARE FOR RCH SPONSORED PATIENTS FOR FEWER DOLLARS. THIS IS A FURTHER INDICATION THAT THE GOVERNMENT IS SHIFTING THE BURDEN OF PROVIDING SERVICES AND COMPENSATION FOR THIS POPULATION TO SOUTHEASTERN MICHIGAN HOSPTIALS.

THESE PHENOMENA, INCREASING PERCENTAGES OF POOR PEOPLE, A DECLINE IN THE NUMBER OF PERSONS SPONSORED BY GOVERNMENT PROGRAMS, AND DECLINING COUNTY EXPENDITURES FOR INDIGENT CARE COMBINED WITH INCREASED HOSPITAL UNCOMPENSATED CARE DEDUCTIONS FROM REVENUES, ARE CAUSING INCREASING FINANCIAL PRESSURES TO BE PLACED ON HOSPITALS. CONSEQUENTLY, SOUTHEASTERN MICHIGAN HOSPITALS MUST CONTINUE TO ENCOURAGE COUNTIES TO COMPLY WITH THE STATE SOCIAL SERVICE ACT AS IT RELATES TO THEIR RESPONSIBILITIES TO PROVIDE FOR THE CARE OF INDIGENT PERSONS. IF COUNTIES ARE UNABLE TO MEET THIS RESPONSIBILTY THEN THEY SHOULD BE ENCOURAGED TO SUPPORT EFFORTS TO PERSUADE STATE AND FEDERAL GOVERNMENTS TO ACCEPT GREATER RESPONSIBILTY FOR THOSE PERSONS UNABLE TO PAY FOR THEIR CARE.

MOUNT CLEMENS GENERAL HOSPITAL

HOW DOES THE SOUTHEASTERN MICHIGAN INDIGENT CARE PROBLEM RELATE TO HOSPITALS IN MACOMB COUNTY AND MORE SPECIFICALLY MOUNT CLEMENS GENERAL HOSPITAL. MACOMB COUNTY DOES NOT HAVE THE INDIGENT CARE PROBLEM TO THE SAME DEGREE AS OTHER COUNTIES IN SOUTHEASTERN MICHIGAN, HOWEVER, WE ARE EXPERIENCING INCREASED LEVELS OF BAD DEBTS, RCH, AND DECREASING PAYMENTS FROM MEDICAID AND MEDICARE.

IN 1987-88 OUR LOSSES, DUE TO MEDICAID, ARE IN EXCESS OF $2.2 MILLION. OUR LOSSES DUE TO THE RCH PROGRAM AMOUNT TO OVER $300,000, WITH ANOTHER $110,000 IN UNCOMPENSATED CARE.

THE PATIENTS THAT WE SEE COME EITHER THROUGH OUR PRENATAL CLINIC OR THE EMERGENCY ROOM. WE HAVE ONE OF ONLY TWO PRENATAL CLINICS IN MACOMB COUNTY AND OUR EMERGENCY ROOM IS THE ONLY DESIGNATED EMERGENCY DEPARTMENT IN MACOMB COUNTY ACCORDING TO THE MDPH CATEGORIZATION METHODOLOGY. OUR EMERGENCY ROOMS IN THE SUBURBS ARE ALSO EXPERIENCING THE DREADED RESULTS OF THE DRUG CULTURE SPREADING THROUGH OUR SOCIETY. THIS RESULTS IN MULTITUDE OF MEDICAL AFFLICTIONS THAT ARE SEEN AS A RESULT OF ITS USAGE; OF COURSE, THE SERVICES ARE GENERALLY NOT PAID FOR BY THE RECIPIENT OF THE CARE. AS THE DRUG TRAGEDY CONTINUES TO GROW UNABATED THIS WILL CONTINUE TO STRAIN THE HEATH SYSTEM RESOURCES.

ONCE AGAIN, THANK YOU FOR THE OPPORTUNITY TO PRESENT OUR CASE TO THE SUBCOMMITTEE ON HEALTH STUDYING THE INDIGENT CARE PROBLEM.

RESPECTFULLY SUBMITTED,

RALPH J. LA GRO
PRESIDENT/CEO

TABLE 1

Background

Since 1987 select low income indicators such as General Assistance, Aid to Dependent Children, Medicaid, and the Food Stamp Program have all shown a substantial decrease in the number of persons enrolled (Table 1 and 2). At the same time 14.5% of Michigan's population were in poverty in 1987 or about 661,078 persons in southeastern Michigan. Furthermore, during this same period southeastern

Table 1

Selected low income indicators for southeastern Michigan and its seven counties 1982 and 1987

	Aid to Dependent Children		General Assistance		Medicaid	
Region and Year	Average Monthly Cases	Total Payments	AverageMonthly Cases	Total Payments	Average Monthly Cases	Total Payments
Southeast Michigan						
1982	411,179	$611,834,458	76,393	$171,036,652	250,152	$694,080,727
1987	342,194	$601,151,893	82,206	$176,386,852	227,421	$905,591,192
Livingston						
1982	3,864	$5,830,591	329	$713,697	2,342	$8,961,091
1987	2,240	$4,076,815	283	$550,145	1,809	$6,519,032
Macomb						
1982	27,161	$42,307,926	3,054	$6,675,300	17,273	$49,417,621
1987	14,543	$27,275,859	2,001	$4,033,296	13,219	$62,655,548
Monroe						
1982	8,187	$12,103,680	821	$1,798,689	4,745	$12,135,425
1987	7,468	$13,457,334	1,425	$2,606,754	5,137	$16,790,185
Oakland						
1982	39,036	$60,255,224	4,133	$8,792,396	24,983	$64,958,350
1987	29,330	$54,822,210	4,747	$9,213,298	22,976	$93,888,157
St. Clair						
1982	11,040	$16,724,170	1,395	$3,051,244	6,292	$11,402,961
1987	9,278	$16,973,889	2,062	$3,973,875	6,926	$17,734,919
Washtenaw						
1982	11,285	$17,200,494	1,593	$3,550,357	7,081	$17,472,809
1987	8,526	$15,894,338	1,375	$2,833,474	6,671	$25,821,256
Wayne						
1982	310,606	$457,412,373	65,068	$146,454,969	187,436	$529,732,470
1987	270,809	$468,651,448	70,313	$153,176,010	170,683	$682,182,095

Source: *Program Statistics*, Michigan Department of Social Services, DSS publication 170, 1982, 1987
Medical Assistance, Michigan Department of Social Services, DSS publication 122, 1982, 1987

Table 2

Monthly average number of households in southeastern Michigan issued food stamps, 1982-1987

	1982	1983	1984	1985	1986	1987
Receiving Public Assistance	173,639	190,723	200,424	182,935	166,756	151,473
Not Receiving Public Assistance	51,742	56,729	50,962	46,901	43,493	42,648
Total	255,381	247,452	251,386	229,836	210,249	194,121

Source: *Program Statistics*, Michigan Department of Social Services, DSS Publication 170 1982-1987

Michigan hospitals saw their uncompensated care increase from $140 million in 1985 to $196 million in 1987 (see Figure 1). While uncompensated care increased by $56 million in a two year period of time (1985-87) county expenditures for RCH declined by more than $3.8 million in just a one year period of time, 1986-1987 (see Table 3). RCH patient days also increased during this time which means southeastern Michigan hospitals provided more care for RCH sponsored patients for fewer dollars. This is a further indication that government is shifting the burden of providing services and compensation for this population to southeastern Michigan hospitals.

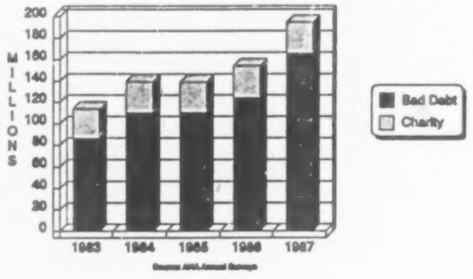

Figure 1

Uncompensated Hospital Services at Southeastern Michigan Hospitals

These phenomena, increasing percentages of poor people, a decline in the number of persons sponsored by government programs, and declining county expenditures for indigent care combined with increased hospital uncompensated care deductions from revenues are causing increasing financial pressures to be placed on hospitals (see Table 4). Consequently, south-

TABLE 3

MEDICAID - 1988

	Medicaid	RCH
1. Billed	$8,020,000	$414,000
Collected	3,924,000	207,000
Loss*	1,070,000	51,000
*Costs associated with program	4,994,000	258,000

2. ER Patients:

		% Revenue
Inpatient	572	9.41%
Outpatient	4,695	11.03%
RCH	68	---
Total	5,335	

Prenatal Clinic Patients:

Inpatient	305

Outpatient: Some Lab & Ultrasound as Public Health Patients

3. Deductible: Not applicable

4. Uncompensated Care: $110,000

Table 3

1988
PERCENTAGE OF REVENUE

Payor Type	Inpatient	Outpatient
Medicaid	9.41	11.03
Other	.01	(.01)
Blue Cross	28.68	34.25
Patient Pay	7.37	14.86
Commercial	17.32	27.14
Medicare	36.30	12.11
HMO	.91	.55
Industrial Clinic	--	.07
	100.00%	100.00%

MEDICAID - 1987

Medicaid Revenue	$6,104,460
Operating Expenses	4,306,232
Gross Margin	$1,798,228
Allowances:	
Loss of Margin	$1,798,228
DRG Impact (Favorable) Unfavorable	999,658
Fee Screen Impact Unfavorable	292,342
Total Allowable	3,090,228
Operating Income (Loss)	$1,292,000

To whom It May Concern

It would Be a Blessing and such a peace of Mind to Know that I Would Have Health Insurance. I am a Middle aged Woman who Cannot get a job that offers Health Insurance, I am un-skilled and I am Having a Hard time Keeping up my premiums.

I Wouldnt Mind paying Some premium, But

Net $122.00 a month.
at 1000.00 deductable.

Please help!!

Mrs. Susan Moscon
22111 David
E. Det, Mich
48021
313 774-869

Thank You!!

Anahid Kulwicki, R.N., D.N.S.
Oakland University
School of Nursing
Rochester, Michigan

and

Researcher/Project Director
Arab American Community Service Center
for Economic and Social Services
Dearborn, Michigan

My name is Anahid Kulwicki. I am assistant professor in the School of Nursing of Oakland University and researcher at the Arab Community Center for Economic and Social Services (ACCESS) in Dearborn. I also am the chairperson of the Problem Identification Committee of the Infant Health Promotion Coalition of Detroit/Wayne County and have served on the Governor's Task Force on Minority Health in Michigan. I am pleased to provide my thoughts and recommendations on access to health care for the uninsured, particularly the uninsured within the Arab-American community.

I would first like to take this opportunity to summarize the health status of Arab-Americans in Michigan. Many of us are aware that Michigan is the home of the largest Arab-American communities in the United States. An estimated 250,000 Arab-Americans live in Michigan and this number is growing with the influx of new Arab immigrants each year. Despite the numbers of Arab-Americans, data on their health status is minimal and in some cases, nonexistent. The scattered body of literature available to us points to the problems of high unemployment (about 35%); an estimated rate of infant mortality of 38.5/1,000; an illiteracy rate in English of 33%; over 20% have no health insurance, marriage among females is early; there is a growing rate of drug abuse in communities which were once virtually drug and crime free; and a great many underemployed individuals lack health insurance.

The barriers in accessing health care for the uninsured Arab-Americans are similar to those faced by other minorities in Michigan. Economic barriers include lack of transportation, geographic isolation from health care locations, availability and affordability of child care, and lack of funds. Other barriers include unsupportive attitudes of health care providers, lack of Arabic Language health care providers or bilingual translators, lack of public information in Arabic about health care resources and disease prevention, and acculturation stresses experienced by those in need of health care.

The Governor's Task Force recommendations to address minority health problems included improvement of data collection on minorities in Michigan, and increased funding of health promotion and disease prevention projects. Based on the Governor's Task Force's recommendation, an Office of Minority Health was established to improve the health status of minorities in Michigan. In recognition of the health crisis among Arab-Americans, the Michigan Office of Minority Health has responded quickly to meet urgent needs. The Office now funds several research and education programs for Arab-Americans.

I believe that health care should be affordable, accessible and available for the economically disadvantaged, the underemployed and should be a right and not a privilege for all Americans. My recommendations to improve access to health care services for Arab-Americans and other minorities include the following:

1. Low cost or no cost health insurance for the underemployed and the unemployed.
2. Provision of community-based comprehensive primary health care services that target families rather than individuals. I would like to make five points in support of my recommendations:
   a. Comprehensive primary health care services that are ethnolinguistically relevant and culturally sensitive will reduce cultural and structural barriers to health care and hence improve access to services by uninsured and high risk populations.
   b. The focus of primary health care services is health promotion, disease prevention and therefore, risk reduction among economically disadvantaged populations.
   c. Community-based comprehensive health care services respond to community needs and empower the community in making decisions and engage in self-help activities.
   d. Community-based organizations employ community residents in rendering health care services and, hence, create or encourage positive role models. This can be an important factor for recruiting minorities and members of high risk populations in health care professions.
   e. Family-centered services can strengthen family units and make a greater impact on the community as a whole.

James Opferman, M.S.W.
1000 Gratiot Blvd.
Marysville MI 48040

June 16, 1989

Senator Donald Riegle
700 Washington Square Bldg.
109 W. Michigan Avenue
Lansing MI 48933

Dear Senator Riegle,

Thank you for your invitation to the hearing on June 28 at St. John's Church in regards to access to health care for the uninsured. I will be unable to attend the meeting but wanted to provide some written testimony about my concerns as you suggested.

My current work responsibilities are the coordination of Respite Care Services for persons who are mentally retarded and live at home with a parent or guardian. Services are available to all St.Clair County citizens who are retarded mentally or are mentally ill living at home. Community Mental Health of St.Clair County subsidizes part of the costs and the family, when able, pays part.

Briefly, the Respite Care program provides a cadre of trained sitters for in-home respite care, and some foster homes for out-of-home respite to our clients and their families. While the client is in care, the parents/guardians are able to take a break from their sometimes 24-hour-a-day responsibilities. The program supports families who have chosen to keep their retarded family member at home. The program works well, although we live with a continuous threat of program money cut backs or program elimination as the state attempts to present a balanced budget. Prevention programs such as mine, in mental health, or general health arenas, are almost always the first to be eliminated or downsized in a fiscal crunch.

In my work as respite coordinator, I receive an average of 2 calls per week from families with other kinds of disabled and dependent members who have chosen not to institutionalize them. Many times these persons only need a break away for 5-10 hours a week in order to maintain their own stability. Typically also, private provider's fees are more than can be afforded by most families. And private nursing respite is impossible for most families to afford ($50 an hour in some cases).

There is no insurance of which I am aware that pays for respite care.

The strange thing is, these families are often advised to "put your loved one in a nursing home, a foster care home, or some similar setting." A permanent placement in such a setting could range from $1,500-4,000 a month if I have my figures right. Respite care, when appropriate, would cost far less, perhaps $200 a month, but the powers that be will not insure for that respite rate.

I'm now going to list the populations that have approached me for respite care. I'm not funded out of my program to meet their needs, which are every bit as valid and sometimes intense, as the needs of families I do serve.

Populations With Unmet Respite Needs

- Alzheimer's patients
- Elderly patients with effects of severe stroke
- Persons with the kind of cancer(s) that require constant attention
- Medically fragile infants
- Mentally Ill parents with unimpaired children.
- Closed Head Injured patients and families
- Infants prone to SIDs possibility
- Physically handicapped children and adults who cannot care for basic needs
- Comatose or semi-comatose persons from cerebral vascular accidents.

All of these families and more have their loved ones at home and will keep them at home as long as possible or appropriate, but need occasional breaks for continuous care duties.

Sometimes after I get a call from such a family, I personally will call providing agencies to discover what respite care they may provide, but almost all the time I hear that these particular families do not meet the agency's criteria, and many times do not offer respite anyway. The so-called gaps in service are sometimes actually chasms. On top of it, there is no relief for the required respite help from any insurer.

Respite Care sometimes is called "soft social work." a misnomer at best. It seems to me that families who have chosen to maintain their loved but dependent member at home deserve support in the form of an occasional break in time that is affordable to them, and supported in some way by public money. In my program, many families say that Respite care improves the quality of their family life. For others it gives them just enough edge to enable them to continue maintaining their loved one in the natural environment of their own home. Institutions need to exist I suppose, and receive funding and support from insurers, but these families I've described need support as well.

I hope this testimony in some way is effective in promoting a change for the better for these and other like families.

Sincerely,

James Opferman

James Opferman, M.S.W.
Respite Care Coordinator
FAMILY SUPPORT SERVICES

JO/lm

6-28-89

Good morning Senator Riegle and members of this hearing panel.

My name is John F.Ostrowski, I am the President of the Genesee County Alliance for the Mentally Ill,Family Support Inc. Our organization is made up of men and women who have a Mentally Ill lovedone. We advocate for the Mentally Ill whenever an oppertunity presents its self.

I am also a volunteer represenative payee in the Homeless outreach program in Genesee County.

Many of the Mentally Ill of Michigan are serviced by Medicade and Medicare approximately 10% are not.When you consider that the Michigan Department of Mental Health estimates according to their programs policy guidelines in 1987 there were 730,000 Mentally Ill people in Michigan and the number is growing,that there are approximately 73,000 Mentally Ill people who are uninsured.Largely due to the fact that these are people who work for minimum wage employers who do not have insurance programs for their employees. Can you imagine trying to work when you are having delusional thoughts or halucenating. This segment of our society certainly should have some kind of insurance to help pay for their very necessary medications and health needs to help them cope and survive in our society.

The rest of the Mentally Ill population,most of which are covered by Medicade or Medicare suffer too.These insurances do not begin to provide the coverage necessary. #1 Medicare will not provide hospitalization if the hospital is not affiliated with Medicare.

One of the Mentally Ill person that I am payee for was unvoluntarrily committed to Ypsilanty State Regional Hospital and Medicare would not pay any part of the bill. So the patient who is on public assistance was presented with a $1600.00 bill.#2 Medicade does not pay any part of eyeglasses if a patient needs them unless it has not been more than six weeks since he or she has had cartiac surgery. Ladies and gentlemen how can we expect these people to survive when we provide them with this kind of innadequate insurance coverage.

Medicade on the other hand is some what better. However there are certain gaps in this coverage also. #1 While Medicade will cover a certain amount of Hospitalization the length of time is restricted. Mental Illness is probably the hardest Illness to predict the amount of time that a patient needs to obtain some kind of stability so that they can function in society. Some may only need a couple of weeks,others need longer hospital stays and still others will have to be Hospitalized for their entire life.

Premature discharges from Hospitals are undoubtably the cause of repeat hospitalizations. I believe that hospital costs could be significantly reduced if hospitals would keep patients long enough to do the job right the 1st time.

#2 Many of the seriously Mentally Ill self medicate. If you have a dual problem of Mental Illness and substance abuse there is very little hope for you because substance abuse clinics who honor Medicare or Medicade are few and far beteween. These are only a few of the insurance problems that one of the most vulnerable segments of our society face. So please do something legislatively to see that the uninsured in our society are helped but do not stop there make sure that the insurance programs we do provide do infact provide the coverage that these people need so desperately.

Thank you for allowing me to speak on the Mentally Ill of our society.

Sincerely yours.
John F.Ostrowski
413 Chestnut St.
Flushing,Michigan 48433
313-659-5859.

John F. Ostrowski

June 20, 1989

Mr. Donald W. Riegle, Jr.
United States Senate
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, MI 48226

Dear Senator Riegle:

Thank you for the invitation to the Senate Finance Subcommittee hearing on June 28, 1989. Although I will be unable to attend myself, I have passed your letter on to John W. Day, President, Allied-Signal, Inc. (my employer). Mr. Day shares our concern of ever-increasing health costs and the fact that so many Americans are without any health insurance.

I have enclosed copies of two recent articles relating to medical costs. I believe the effects of these spiraling costs affect our competitiveness and weaken the national economy. It is time to consider our alternatives. Other first world countries spend significantly less on health care with no obvious loss in longevity or birth rates. Corporations spend millions in joint ventures to improve products and their costs; why can't the government, business and medical communities form a joint venture to provide health care to everyone and reduce costs while doing so?

As a nursery volunteer at Detroit's Hutzel Hospital, I have seen time after time the effects of no medical treatment. Babies born prematurely, sometimes drug-addicted and/or HIV-infected, at dangerously low birth weights; mothers with no prenatal care, and probably little to no care when they leave the hospital. These people deserve more - we cannot simply stand by and ignore their plight.

I applaude your efforts and wish you great success. If I can assist you in any way, please do not hesitate to ask. Thank you again for keeping me informed of your good work.

Sincerely,

Penny Van Over

Penny Van Over
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Detroit, MI 48239
(313) 827-5501 (work)

Enc.

NEW YORK TIMES
NEW YORK
May 8, 1989

A Health-Care Taboo Is Broken

By MILT FREUDENHEIM

Facing at least $5 billion in employee medical costs this year, many automobile industry executives acknowledge that their efforts to control costs have failed, and they are calling for drastic changes in the way the nation pays for health care.

Lee A. Iacocca, chairman of the Chrysler Corporation, is even talking about the merits of national health insurance, long a taboo subject in most board rooms. Chrysler, which was boasting a few years ago about its success in holding down employee health costs, has seen its annual spending on employee health care grow to $702 million last year, from $432 million in 1985.

Executives at Chrysler and the Ford Motor Corporation, which spent more than $1 billion on employee health care last year, are buttonholing counterparts in other industries and officials in Washington to argue that the private sector's attempts to control health-care inflation have failed.

"We are looking for a magic bullet," said Jack Shelton, manager of employee insurance at Ford.

Executives at the General Motors Corporation agree with their colleagues at Ford and Chrysler that rising health-care costs are damaging Detroit's competitiveness, weakening the national economy and adding hundreds of dollars to the cost of each car and truck. But G.M., which spends more than $3 billion on employee health, has not joined in calling for radical change.

The nation's health bill has risen to $590 billion a year. Private insurance, most of it financed by employers, is paying nearly a third.

The continuing sharp rise in health-care costs reflects increases in the number of visits to doctors, the volume of expensive medical tests and the costs of prescriptions. A new financial accounting rule threatens to make the problem worse by requiring companies to acknowledge billions of dollars in liabilities for the future care of retirees.

The Financial Accounting Standards Board, which makes the rules for corporate America, has drafted regulations requiring all companies to account for their commitments to pay for retirees' health care as a cost of doing business and a current liability. The board is currently accepting comments from industry on the rules, which are to take effect gradually, starting in 1992.

Companies with comprehensive health plans say they are in effect subsidizing health care for the rest of the country through inflated payments to hospitals and doctors.

"Health care is the issue of the hour, the No. 1 concern of our members," said Sara Hillgrove, a spokeswoman for the National Association of Manufacturers, which recently polled its 13,500 members and is preparing a report that will examine alternatives.

Concerns Will Be Heard

Government officials said the growing concerns about health spending among businesses would eventually make itself felt in Congress.

"The health issue is back on the American agenda," said Senator Edward M. Kennedy, chairman of the Senate Labor and Human Resources Committee. "At last, the cost is hitting the middle class, and American business is understanding the effects on the bottom line."

Senator Kennedy began committee hearings last week on his bill, which would set minimum health-care standards for all full-time employees and would develop a public program for the uninsured.

Senior Bush Administration officials agree that the health system is in trouble, but the Administration opposes the Kennedy bill as well as more far-reaching proposals that would expand the Government's role.

"I don't believe the answer is putting the Government in charge of the system," said Dr. William L. Roper Jr., deputy assistant to the President for domestic policy and former head of the Federal Medicare program. "The Government, the private sector, individuals need to be much more aggressive in constraining the costs of the system and assuring that their dollars are spent on effective services."

Measures Have Been Taken

But the three auto makers point out that their costs have continued to rise despite measures like requiring second opinions from doctors before authorizing surgery and persuading employees to join health maintenance organizations or use doctors who accept discounted fees. Chrysler estimates that without such measures, its health costs would have increased an additional $1.3 billion in the last seven years.

Both General Motors and Ford said their fastest-growing health cost was for prescription drugs. Tom J. Morr, general director of employee benefits at General Motors, said G.M. had paid $275 million for "a mind-boggling" 14 million prescriptions in 1988. The cost rose 22 percent, from $225 million for 13 million prescriptions in 1987.

Ford and Chrysler say they are studying a variety of proposals for sweeping changes, but they have not decided which ideas to endorse.

Walter B. Maher, director of employee benefits at Chrysler, said he is impressed by Canada, where the Government negotiates annual budgets with regional groups of doctors and hospitals.

50% More Than Canada

"We spend almost 50 percent more per capita on health care than Canada," he said. "When you look around the world, there appears to be a common denominator: a process that gets all the players involved in a political decision as to how much of their money as a nation will be set aside for health care."

The American automobile industry has been especially vulnerable to the surge in health-care costs because it offers generous health benefits to an enormous, aging work force of 1.3 million active and retired workers and more than two million of their dependents. The contracts with the United Automobile Workers union, which guarantee extensive benefits, are up for renewal next year, but neither the union nor the companies expect benefits to be cut in contract talks.

In 1988, the car makers paid about $5,800 for health care for every active employee, nearly three times as much as the corresponding amount in Japan. The "health tax," as some in the industry call it, is expected to go even higher on a per-vehicle basis if production declines this year, as industry experts have predicted.

"American industry cannot compete effectively with the rest of the world unless something is done about the great imbalance between health-care costs in the U.S. and national health care systems in virtually every other country," Mr. Iacocca said. "That's why a national health insurance program for the U.S. is being discussed widely for the first time since the late '70's.

"Such a program would be a huge risk, and would require that Government, management and labor come together. But competitive pressures

> Auto industry officials say they failed to limit medical costs.

are building up to try something different," he added.

Mr. Iacocca is taking his concerns to business leaders and the public in speeches and articles.

"How would you like to compete without this albatross around your neck called runaway health costs?" he asked in a recent speech at the annual meeting of the National Association of Manufacturers in Washington. "For me, it's $700 a car, and still going up at twice the rate of inflation. Other countries put those costs in their taxes, but we put them into the price of our products."

General Motors, the nation's largest industrial company, said it spent more than $3 billion, about $600 for each vehicle it produced, to insure the health of about two million people last year, comprising 480,000 active employees, 318,000 retirees, and their 1.2 million dependents.

Ford, the country's second-largest industrial company, spent $1.18 billion on health care in 1988, insuring 270,000 auto workers, 114,000 retirees and about 700,000 dependents. Chrysler, which covered 109,000 active employees, 86,000 retirees, and 245,000 dependents, spent $702 million.

Executives said the amounts would rise at least 10 percent at all three companies, which, like most large employers, are self-insured.

On the competitiveness issue, Joseph A. Califano Jr., chairman of the Chrysler board's health-care committee and former Secretary of Health Education and Welfare, said Chrysler's health-care cost of $700 a vehicle was double the amount in France and Germany and triple the amount in Japan, all three of which have nationalized health care.

To be sure, analysts point out that the costs per vehicle are not a consistent measure of health costs, which may vary widely as sales rise and fall. The comparison of health costs per car to profit margins is also complicated, they say.

One widely used measure, which excludes overhead costs, puts the average profit margin of an equipped car at General Motors last year at about $4,000, said Maryann Keller, an analyst at Furman Selz Mager Dietz & Birney.

Elliot Richardson, who was a Secretary of Health, Education and Welfare in the Nixon Administration, is skeptical about the prospects for slowing health costs.

He said Americans would not tolerate the delays that are common in some other countries in obtaining medical care. "It is characteristic of us that if a new and better treatment is available, we want it as soon as we can get it and we really don't care what it costs," he said.

NEW YORK TIMES
NEW YORK
May 15, 1989

Employers Battling Doctors To Cut Worker Medical Costs

By GLENN KRAMON

On their own or in coalitions, employers from Procter & Gamble to the State of Arizona are aggressively bargaining with doctors and hospitals eager for their business, and increasingly steering their employees to the ones agreeing to the best price.

Seeking to slow the sharp growth in their health-care costs without depriving workers of care, the employers are using their size to gain leverage in negotiations. In short, they are trying to deal with doctors and hospitals as they deal with any supplier, demanding high quality at the lowest price.

"Employers used to just pay the bills," said Dr. Edward F. X. Hughes, director of the Center for Health Services and Policy Research at Northwestern University. "Now, as a prerogative of paying the bills, the employer is choosing where you can go."

Stronger Incentives

To be sure, for most of the decade many employers have offered networks of doctors and hospitals as an option to employees. For example, employees can join health maintenance organizations, which provide care at a predetermined price no matter what the cost of treatment, or preferred provider organizations, which offer discounts on customary charges.

But now, many employers are putting more time into arranging these networks and making them the centerpiece of their health plans. Unlike an H.M.O., the networks will cover some of the cost if an employee decides to see an outside doctor. But employers are creating much stronger financial incentives for workers to use the networks, paying a much greater portion of the bill if they do.

Too New to Evaluate

While such networks have already been started in cities across the country, most are so new that it is difficult to determine their success. But some corporate benefits managers estimate that their companies are paying 10 to 35 percent less than under conventional programs. Employees at those companies, who pay some of their own health-care costs, are saving money.

But many health-care analysts and organizations are concerned that the networks are doing little to control overall health costs and might even reduce the quality of care. They are also troubled by predictions that companies will make it increasingly expensive for employees to go outside the networks.

"Under these contracting arrangements, the patient loses the freedom of choice," said Dr. James S. Todd, a senior executive of the American Medical Association. "And the contract may have been negotiated so thinly that the physician decides to use a treatment that is cheaper rather than better."

Richard A. Maturi, executive director of managed-care programs at the Blue Cross and Blue Shield Association, conceded: "While we can make the networks cost-effective compared with uncontrolled programs, that doesn't necessarily solve the long-term escalation of health-care costs. There are still underlying forces, like new technology and the aging of the population."

While employers hope that limiting their payments will force hospitals and doctors to become more efficient, that is not always what happens. The providers, already facing payment limits under the Federal Medicare and Medicaid programs, sometimes merely raise their charges for people at companies without such contracts and for people who buy their own health insurance. The providers can also offset the discounts negotiated with employers by, say, having patients make unnecessary office visits.

Employers also concede that although they try to find the best doctors and hospitals in a community, they often end up choosing providers more on the basis of price than performance. Price may also be taken into account more than the preference of employees for doctors who are convenient and known to them.

Employers See No Alternative

It is a difficult situation for American employers. "Health care is not something we're expert in, but we don't see a choice other than getting involved unless we want to spend 20 to 30 percent a year more or shift more of the costs to employees," said Patricia M. Nazemetz, benefits director of the Xerox Corporation.

Later this year, Xerox will select four or five networks to serve its 100,000 employees and dependents.

Employers are taking a number of approaches in negotiating contracts. Some, like The Washington Post, Navistar, Adolph Coors and many smaller businesses, have teamed with other employers in their cities to form "purchasing groups" for health care.

Others, like Procter & Gamble, the State of Arizona, Allied-Signal and Southwestern Bell, have signed contracts with Cigna, Prudential, Metropolitan Life and other large insurers that are organizing medical networks. Sometimes the insurers agree to absorb some or all of the medical-cost increases above a certain amount.

Employees at Boeing and more than six million people at small and medium-sized employers are covered by networks arranged by Blue Cross/Blue Shield.

And some employers, like Chevron, Safeway Stores and Lockheed, have hired consultants to organize networks tailored to their employees.

Under many of the contracts, a hospital will offer a discount or accept a per-diem or per-case rate regardless of the cost of treatment. Physicians outside the hospital agree to a fee schedule for many services, or at least to a discount on their usual charges.

Review Programs

The doctors and hospitals also accept a review program aimed at eliminating unnecessary or inappropriate procedures.

In return, employers agree to steer their workers to the network's hospitals and doctors by paying a larger share of the expenses of employees who use the network — say, 90 or even 100 percent instead of 80 percent or less.

Unionized employees must agree in collective bargaining to participate in such networks; most union officials support the concept, as long as the networks are carefully arranged.

But the savings through the networks can come at a price, experts say. "Your company may be paying less, but someone else is paying more," said Dr. Michael J. Martin of Mercer Meidinger Hansen Inc., a consulting firm in San Francisco. "The hospitals' costs are not necessarily being reduced; they're just being shifted. So all the poor employers who haven't arranged discounts, and the private people who are buying health insurance themselves, are subsidizing the companies that have discounts.

"California, for example, has some of the highest employer discounts in the country, and also some of the highest costs for people who don't have discounts. The cost for an average nondiscounted day for a hospital in the San Francisco area is now over $1,300."

Many large employers acknowledge that they must not be too ruthless in their bargaining. "You walk a line," said Janice H. Ypsilantes-Hein, health-care programs manager of Navistar. "If you go too low, you have to be concerned that there will be a problem with the quality of care."

'Going With the Lowest Bidder'

Another difficulty with the networks, almost everyone agrees, is that hospitals and doctors are selected mostly on the basis of price. "Most businesses don't know health-care quality when they're looking at it," said Charles B. Inlander, president of the People's Medical Society, a consumer group in Allentown, Pa. "So what they end up doing is going with the lowest bidder."

And Carol M. McCarthy, president of the American Hospital Association, said, "What we have now is only gross screening techniques."

For example, in deciding whether to include a doctor, most networks will examine licenses and other credentials, admitting privileges at hospitals and patient complaints and disciplinary actions in government files.

The screening process is improving. Dr. Michael R. Soper, national medical director of Cigna, noted that patient satisfaction can be measured through telephone surveys. Hospitals and doctors who do not fare well are informed so they might improve; if they do not, they can be dropped from the network.

Doctor Comparisons

Not so easy to measure is whether a medical provider is efficient, avoiding unnecessary procedures that could add to costs, Dr. Soper said. Cigna has begun to compare the treatment patterns of doctors in the network with their peers. Again, the results are shared with doctors.

And it is most difficult to gauge the quality of care, Dr. Soper said. At some point there will be more systematic use of indicators like the rates of mortality, postoperative infections and complications, all adjusted for factors like age and the severity of the illness.

Some networks now accept almost any doctor or hospital. As the means of selecting providers improve, the networks could become more exclusive. Then, said David V. Repko, a benefits consultant in Cleveland for the firm of Towers, Perrin, "you will probably see systems that have even more steerage of employees."

June 27, 1989

Dear Senator Riegle,

I received your notice of the health care hearing just this afternoon and am rushing a hand-written response to you now, as the hearing is tomorrow.

This should indicate to anyone who reads it that I consider the issue of insurance for the un-insured of utmost importance. Please do all you can to help people who truly need it.

My testimony:

I was a single mother in 1981 - 28 years old at the time - supporting my daughter - then 7 yrs. old - by working as an independent sales person for cosmetics. I worked very hard and earned plenty of money to support us. I was not receiving a dime from my child's father.

Everything was great - until I got eczema. It devastated me. I had this horrible condition on the palms of my hands and the soles of my feet - and after a year I had spent $6,000 on medicines and doctor visits. My condition got worse - and I developed phlebitis - which can be fatal. I had no insurance and could not be hospitalized. I was unable to walk for six weeks at one point - and when I got slightly better I took a job with Kelley Services as an executive secretary part time - whenever my skin would allow me to work. At the time that I had phlebitis my doctor told me to seek Medicaid, as my condition was going to continue.

Well, I did. And it was wonderful that I had that Medicaid card to see my condition through the rough periods.

The part that is really bad - when I would have the medicine, I would get better and be able to work. When I worked, they took my medical coverage away. I didn't care to have my rent paid or food stamps - while I was able to work. But without my Medicaid card I couldn't make enough to cover my medical expenses. It is so silly.

The welfare system would send me letters and call me - telling me I had to sign up to be trained to be "self supporting". It was so insulting. I was quite capable of supporting myself and my daughter. I was physically unable for most of four years to do it. I had the skills - just not the use of my hands and feet!

Please excuse the messy writing. I'm trying to get this in the mail so that it will reach you by tomorrow.

I got remarried in 1985 to a Chrysler employee. We now have wonderfull medical coverage - and it is such a relief. I'm still under constant doctor's care for my condition.

Even though I don't have a need right now, personally for this health care you are striving to provide - I care enough about the issue to have shared my testimony with you - and your contingency.

Please consider this -

Not all people on welfare are the dirt of society. Some of us had physical handicaps that stripped us of our dignity - just in order to get medical treatment. It is a sad, sad shame.

Mr. Riegle, I'm so glad you are making this an issue for all of us. Please respond to this letter by letting me know what happens at your hearing. Thank you.

Sincerely,
Donna Jean Parman
40823 Freedom Dr., Sterling Hts, MI 48078
313-247-3637

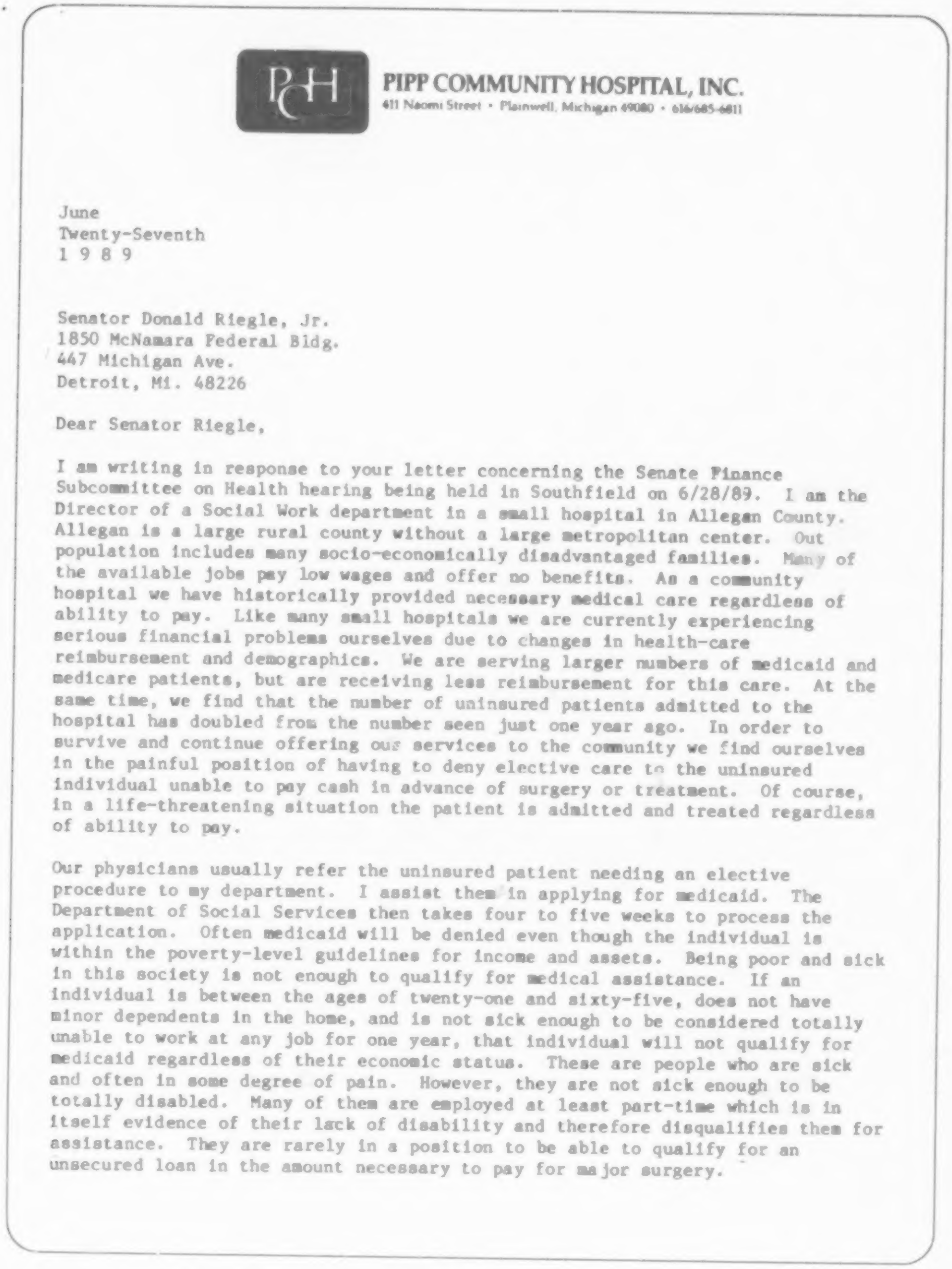
Erik Peterson
28034 JAHN
Roseville, Mi 48066

Dear Senator Riegle:

I received your leaflet on your hearing about health insurance. I did go down to southfield and did want to talk about my insurance problems. I was laid off and now I carry a COBRA policy. I feel the premiums are too high, The premiums on high risk Blue Cross are less. Right now I work as a tempory for Kelly Services, anyway I would like to hear for you as to how the hearing did go. like I said I did drive down there but got confused with streets (Northwestern Turns into southfield) and a X-way runs ~~away~~ along, anyway I got lost.

yours Truly,

Erik Peterson



PCH PIPP COMMUNITY HOSPITAL, INC.
411 Naomi Street • Plainwell, Michigan 49080 • 616/685-6811

June
Twenty-Seventh
1989

Senator Donald Riegle, Jr.
1850 McNamara Federal Bldg.
447 Michigan Ave.
Detroit, Mi. 48226

Dear Senator Riegle,

I am writing in response to your letter concerning the Senate Finance Subcommittee on Health hearing being held in Southfield on 6/28/89. I am the Director of a Social Work department in a small hospital in Allegan County. Allegan is a large rural county without a large metropolitan center. Out population includes many socio-economically disadvantaged families. Many of the available jobs pay low wages and offer no benefits. As a community hospital we have historically provided necessary medical care regardless of ability to pay. Like many small hospitals we are currently experiencing serious financial problems ourselves due to changes in health-care reimbursement and demographics. We are serving larger numbers of medicaid and medicare patients, but are receiving less reimbursement for this care. At the same time, we find that the number of uninsured patients admitted to the hospital has doubled from the number seen just one year ago. In order to survive and continue offering our services to the community we find ourselves in the painful position of having to deny elective care to the uninsured individual unable to pay cash in advance of surgery or treatment. Of course, in a life-threatening situation the patient is admitted and treated regardless of ability to pay.

Our physicians usually refer the uninsured patient needing an elective procedure to my department. I assist them in applying for medicaid. The Department of Social Services then takes four to five weeks to process the application. Often medicaid will be denied even though the individual is within the poverty-level guidelines for income and assets. Being poor and sick in this society is not enough to qualify for medical assistance. If an individual is between the ages of twenty-one and sixty-five, does not have minor dependents in the home, and is not sick enough to be considered totally unable to work at any job for one year, that individual will not qualify for medicaid regardless of their economic status. These are people who are sick and often in some degree of pain. However, they are not sick enough to be totally disabled. Many of them are employed at least part-time which is in itself evidence of their lack of disability and therefore disqualifies them for assistance. They are rarely in a position to be able to qualify for an unsecured loan in the amount necessary to pay for major surgery.

They are usually shocked and disbelieving when they find that their lack of insurance and financial resources effectively denies them access to the care recommended by their physician. I only wish that these individuals could speak for themselves at this hearing so that you could see and hear their tears, anger, and frustration, as I see and hear it too often.

I am frequently asked by the patients physician if there is another hospital in the area which would accept these patients and provide what is essentially free care. If there is such an institution (and a surgeon on the staff willing to take the case) they would not dare make their presence known as they would be overwhelmed with uninsured indigent patients from the region. The problem of health care for the uninsured, the working poor, and the indigent is growing faster than the resources in the private sector can cope with it. It seems unacceptable to me that people in clear need of medical care are being denied that care for financial reasons. However, when continuing to provide that care will result in a community being left without a hospital due to financial hardships caused by lack of reimbursement, what choice would you make? Please help us not to have to make this choice.

Sincerely,

Kay Harrison

Kay Harrison
Social Services Director

KH:cj

PGH Pontiac
General Hospital

Seminole at West Huron
Pontiac, Michigan 48053
Telephone (313) 857-7200
James Wright, President

Ambulatory Care Center of Waterford
1305 North Oakland Boulevard
Pontiac, Michigan 48054
Telephone (313) 666-9000

Pontiac Health Care Center
132 Franklin Boulevard
Pontiac, Michigan 48053
Telephone (313) 333-3373

June 27, 1989

Senator Donald W. Riegle, Jr.
Chairman, Senate Finance
Subcommittee on Health for
Families and the Uninsured
Century Center Building, Third Floor
30800 Van Dyke
Warren, MI 48093

Dear Senator Riegle:

As health practitioners, we have been first hand witnesses to the results of three exciting and valuable programs made available through State and Federal funding. These endeavors, administered through Pontiac General Health Care Center, include a Teen Health Center at our local high school and a center offering Primary Health Care and the Maternal Support Services Program. We are here today to address how these plans, along with cooperative ventures with local agencies, have impacted on indigent and low income patients. These patients would, otherwise, never have access to the most basic care let alone comprehensive, quality care which we are able to provide to all ages of patients.

We have identified specific problems and the positive impact our programs have had. We have briefly documented the most pressing issues on the attached pages and will cite cases in our testimony today.

The health problems of our patients can be overwhelming, but are manageable. They must be identified and resolved to assure the patient does not become a burden to the community. We appreciate the opportunity to express our comments and viewpoints and trust you will support funding necessary, allowing us to continue to help the growing number of uninsured.

Sincerely,

Michelle Zeeman
Michelle Zeeman
Director
Pontiac General Health Care Center

Catharine Fischer
Catharine Fischer, R.D.
M.S.S.P. Coordinator

Susan Eaton
Susan Eaton, R.N.
Community Health Nurse

Suzanne Maithel
Suzanne Maithel, M.S.N.
Certified Family Nurse Practitioner
Pontiac Teen Health Center Coordinator

PROBLEMS AND SOLUTIONS

PONTIAC GENERAL HEALTH CARE CENTER

P.G.H.C.C. is a primary health care facility sponsored by the Michigan Department of Public Health and Pontiac General Hospital. It offers Family Practice, Internal Medicine, Endocrinology, and Obstetrics and Gynecology with a focus on health education and health promotion. Our professional staff includes a Nutritionist, Social Worker and Community Health Nurse. The center has traditionally offered comprehensive health care to the unemployed, low income, and socially needy population within Pontiac.

Problem: Growing teen pregnancy rates

Women who do not have health insurance tend to delay entry into the health care system, thus, increasing risks to their own health and the health of their unborn child.

Solution:

Since 1986, through a local grant from the March of Dimes, P.G.H.C.C. has offered Free Pregnancy Testing and Family Planning Counseling to all women of child-bearing age in our community. The focus of the program has been to provide women access to health professionals with referrals for continued health care, community and financial services, and health education. The first year we served 240 women and, in 1988, served 600.

Problem: Elderly lack understanding of health care system, as well as transportation to health care providers.

Solution:

Since its inception, P.G.H.C.C. has recognized the need to promote outreach programs and transportation services to our elderly and uninsured populations. The health center regularly visits community and senior centers offering health screening and educational programs. After identifying patients who lack health care, our van transports the patient to our center. The patient is, then, evaluated by our professional staff, which includes a Social Worker, Nutritionist, and financial counselor.

This unique and holistic approach assures that all needs of the patient will be met on an on-going basis.

PONTIAC TEEN HEALTH CENTER

This school based clinic, funded by the Michigan Department of Public Health, Pontiac General Hospital, Pontiac School District, and the Oakland County Health Department, opened February 1989 and serves the 1,300 students enrolled at Pontiac Central High School. Comprehensive medical and counseling services are provided by a full-time Nurse Practitioner under the direction of a designated physician. The center is within the high school and is open all year to make health care accessible to the adolescents.

Problem: Steadily increasing number of Sexually Transmitted Diseases in the teen population.

Solution:
The center has provided confidential comprehensive treatment to stop the spread of venereal disease. The school clinic provides an accessible site to the students to care, as they are reluctant to visit family doctors or unfamiliar clinics.

Problem: Dysfunctional families with limited resources

Solution:

Teens who come from homes with parents who are absent, chemically dependent, or abusive (physical/sexual) have increased emotional, psychosocial, and stress related disorders. A specialized multidisciplinary team provides support, counseling, and community referrals for the teen to successfully cope with these situations.

MATERNAL SUPPORT SERVICES PROGRAM (M.S.S.P.)

The Maternal Support Services Program is an excellent example of a preventative program to improve pregnancy outcomes and, therefore, reduce infant mortality. It provides public health nursing, nutrition counseling, social work counseling, childbirth education, and transportation as adjunct to prenatal care.

Problem: Increasing Infant Mortality rates

Solution:

North Oakland County currently has two Maternal Support Services Programs, both sponsored by Pontiac General Hospital. Since their inception in February 1988, the two programs have served over 180 women during pregnancy and up to 60 days postpartum. A multidisciplinary team of a nurse, nutritionist, and social worker develop and implement an individualized plan of care for each patient. They provide education and counseling services as well as referrals to outside agencies. Frequent referrals are for WIC and Focus Hope, parent support groups, and substance abuse counseling. Both M.S.S. programs offer childbirth education, and patients are able to utilize either site's classes. Oakland County Health Division provides public health nurses to continue in the home what the nurse practitioners initiate in the clinic. The response from program participants has been very positive; pregnant women are usually eager to learn and an ideal audience for behavior change. The best testimony is from a patient herself:

> My name is Lavenia Allums. I am a single mother with two children, a nine year old daughter and a 10 month old daughter. I am 35 years old and consider myself a n older mother because of the large number of teenagers getting pregnant.
>
> When I discovered that I was pregnant, I quit my job, mainly because there were signs posted about toxic contamination in the water and air. So, I quit for the health and safety of the baby and myself. I received unemployment because the company did not deny the toxic situation; but when my unemployment was exhausted, I applied for assistance from the Michigan Department of Social Services. My doctor would not treat me after my insurance was terminated, and he told me to come back when my Medicaid card came. I was ready to change doctors anyway; and a lady I was doing volunteer work for told me about Dr. Oates, a female doctor, which was what I wanted. I called her office, and they got me right in. When they told me just to go bring in my Medicaid card when I got it, I was so relieved that I shed a few tears. I did get Medicaid when I was about four months pregnant.

At the clinic where Dr. Oates works, they have a Maternal Support Services Program. I had to see a Nutritionist to help me with my diet (for me and the baby I was carrying). She gave me literature to read and told me a lot of things I did not know about nutrition and health. I also had to talk to the nurse before seeing the doctor. She is wonderful, too. She has a soft, concerned voice that makes you feel like she cares. She helped me a lot with personal and health problems. She directed the prenatal classes and was very patient with everybody's questions about what to expect when having a baby. Even having a child already, I still learned new things.

I was also having problems with D.S.S. and Medicaid; and I was worried about paying the bills. The social worker I saw at the clinic was great; she helped me with various situations , both at the clinic and at home. When she made house visits, she met my older daughter and helped me with information on young girls maturity.

I also needed transportation on different occasions and, and the Maternal Support Services Program provided transportation from my house to the clinic.

I am working part time now and would have loved to speak today, but I work during this time. I have also applied for a Maternal Child Health Advocate position. I had an advocate who helped me in many ways during the pregnancy and afterward, and I think I could help other mothers in similar situations.

As an older mother, I thought I knew it all, but when you get pregnant and your body chemistry is thrown off balance, nothing seems the same.

Thanks for hearing my outlook on the Maternal Support Services Program that helped me.

June 28, 1989

Senator Donald W. Riegle, Jr.
Chairman, Senate Finance
Subcommittee on Health for
Families and the Uninsured
Century Center Building, Third Floor
30800 Van Dyke
Warren, MI 48093

Dear Senator Riegle:

Thank you for inviting us to attend your hearing on the problems of health care for uninsured on Wednesday, June 28. We regret not having the opportunity to speak at the hearing but were pleased to submit written testimony to be included in the public record.

As a state-funded primary health care center, we support the views expressed by Dr. Michael Boucree of the Hamilton Family Health Center in Flint, Michigan. We also have first hand knowledge of the benefits of providing comprehensive primary care to a population with similar demographics. Had supportive and accessible health care been available to the individuals testifying at today's hearing, it is probable that the acute stages of their disease process may have been circumvented or delayed. Because we have had the funding that allows us to provide health promotion and prevention, as well as direct services, we have seen these tragedies avoided.

We support your perspective that health care is a basic human right and should be available to all Americans. To support this goal, we believe Congress should continue to support Primary Care and Teen Health Centers and foster a more positive environment for physicians, nurses, and other health professionals to practice without the threat of excessive and unfounded litigation. Laws should be enacted to curtail the extravagant cost of settlements and malpractice insurance in Michigan and nationally. The shortage of physicians in the state must be addressed and could be rectified by resolving the malpractice issue and offering loans or incentives in exchange for service to the medically underserved population.

Please feel free to contact us in the future. We would be happy to give you a tour of our centers or answer any of your questions.

Sincerely,

Michelle Zeeman
Michelle Zeeman
Director
Pontiac General Health Care Center

Catharine M. Fischer
Catharine Fischer
M.S.S.P. Coordinator

Susan Eaton
Susan Eaton, R.N.
Community Health Nurse

Suzanne M. Maithel
Suzanne Maithel, M.S.N.
Certified Family Nurse Practitioner
Pontiac Teen Health Center Coordinator

MZ/scr

Ronald W. Hornung
Special Agent

The Prudential
Insurance Company
of America

4745 11 Mile Road
Auburn, MI 48611
Telephone: 517-662-2192

Prudential

To: Senator Donald W. Riegle, Jr.

From: Ronald W. Hornung RHU
Michigan Ass'n of Life Underwriters - State Chairman,
Health and Employee Benefits Committee;
Michigan Ass'n of Health Underwriters - Treasurer

Re: Testimony at Public Hearing for Senate Budget Committee and the Senate Finance Subcommittee on Health for Families and the Uninsured.

Date: June 28, 1989 - Southfield, Michigan

For many years the insurance industry has had an opportunity to respond to public and legislative pressures to create a mechanism to help those people who have no health insurance. It has become obvious to this observer that the current pressure from both state and federal political realms will require prompt action to ward off a major new bureaucracy to address this concern. Still the pressure may be just what the doctor ordered to get a program in place; a fiscally sound program run by the private sector, which will make use of the expertise which already exists rather than create a major new entitlement program which duplicates existing services.

There is no doubt that the type of financial suffering which is caused by necessary medical expenses is, on one hand, the very type of problem which government is most suited to handle and yet, on the other hand, it is a very insurable problem. In other words medical expenses can be accurately and actuarially projected due to the large numbers involved in the calculations. It can be shown that the existing government programs (ie medicare and medicaid) are both very successful (in the number of people receiving needed benefits) and very unsuccessful (reflecting on the waste, fraud and lack of incentives in these programs). Although the same problems can and do occur in the private insurance industry they do so at the expense and control of the policyholder or the shareholder rather than the taxpayer. Yet this is America and if there is any way that a problem can be successfully settled "by the people" it should not be legislated by government.

It has recently been announced that Mr. William Bennett, the Bush administration's "drug czar", is in the process of drafting model legislation to be introduced into State Legislatures to address his field of concerns. In the insurance industry the National Association of Insurance Commissioners (NAIC) has been drafting model legislation to address insurance concerns for many, many years. As in all such endeavors success has been mixed but it is interesting to note that in all states the insurance commissioner (or the equivalent officer) acts in the interest of all parties involved; insurance companies, agents, brokers, the state, and the consumers. Some are elected and some are appointed and it is this mixture of expertise and allegiances that makes most of their model legislation truly "model".

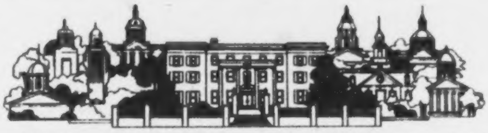
Along with this report I am submitting to this panel a copy of the NAIC's model legislation to establish state risk pools which eliminate the problem of health insurance availability. Also included is a synopsis of the provisions of the adopted versions of the bill for each state. The same type of organization has served the auto and home insurance industry for some time with minimal cost to governmental units.

The fifteen (15) states which have enacted some derivative of this bill should be rewarded for their response to social problems. The other states, some of which have severe insurance problems (ie California), should be assured that the problem can be settled within their states. "....ask what you can do for your country!" Senator Hatch's Comprehensive and Uniform Remedy for the Health Care System Act of 1989 "CURE" which was introduced in Washington on June 23, 1989, addresses these risk pools and offers federal assistance in the establishment of a state pool and other means of addressing the problem. This bill is supported by the National Association of Health Underwriters as being fiscally responsible as well as a more complete solution than other National health care proposals.

This solution (enactment of risk pools) will still require the Federal Government's help in ways in which they are uniquely suited. Some program is necessary for those for whom the premiums (whether or not they are in a risk pool) exceed reasonable budgetary expectations. (Of course, this currently exists in the deduction of premiums in excess of 7.5% of taxable income.) A way should be found to finance medical bills in excess of the lifetime maximums (now ranging from $250,000 up). Insurers should be provided with reinsurance availability to keep the entire system fiscally attractive to all involved investors and insurers. Finally last, but not least, the underprivileged must be assured that a health insurance premium will not alter their benefit amount and will be considered a basic need.

Respectfully Submitted: Ronald W. Hornung RHU
4745 11 Mile Rd.
Auburn, Michigan 48611

State
Legislative
Report



THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS 1922 F ST. NW, WASHINGTON, D.C. 20006-4387

SLR 88-20

June 1, 1988

* * SPECIAL * *

RISK POOLS FOR UNINSURABLES

ACKNOWLEDGEMENT

The charts and information provided with this SLR were in large part compiled by an organization called Communicating for Agriculture which has been very involved in the risk pool issue since 1975. We thank them and the other organizations who have provided information to NALU and who continue to provide information on this important issue.

WHAT ARE RISK POOLS?

Among the uninsured are those who have been denied insurance coverage for reasons of poor health or who have been offered insurance policies with extremely high premiums or with restrictive exclusions for pre-existing conditions. For some of these people, money is not the barrier to health care until such time as large medical bills drain their resources.

In 15 states, high risk individuals now have access to health insurance risk pools. Under such programs, health status is in theory eliminated as a barrier to the availability of health insurance, since insurance is available through the pool.

Clearly, risk pools do not eliminate all barriers to the availability of health insurance, because the insurance obtainable through pools is expensive. Nevertheless, advocates argue that this availability of insurance helps to create a principle that everyone should have the opportunity to purchase health insurance. Second, they argue that health insurance for high risk individuals does address one small segment of the larger population of uninsured individuals.

NALU POLICY

NALU supports the passage of enabling legislation in all states to create reinsurance pools or other mechanisms to fully spread the risks associated with insuring those persons now denied access to adequate health insurance.

HIGH PRIORITY ISSUE

The issue of state pools for uninsurables is a high priority item of NALU's State Law and Legislation Committee. The Committee has been working toward the enactment of legislation creating such pools in all states.

PURPOSE OF THIS SLR

To provide information to all recipients of the State Legislative Report and to urge those states currently not providing a method or mechanism for uninsurables to obtain health insurance to consider taking steps toward the eventual enactment of legislation providing for such pools.

BASIC DESIGN OF A RISK POOL

The basic design of a risk pool is to guarantee availability of adequate health insurance to all individuals, regardless of their physical condition. Although the operation of pools varies considerably from state to state there is a basic pattern. The state generally forms an association of all health insurance companies doing business in the state (proposed federal legislation would permit inclusion of self-insuring business in this association). One organization is selected to administer the plan under the guidelines for benefits, premiums, deductibles, etc. as set forth in the state law. Individuals then are able to purchase insurance from the plan.

COVERAGE

Risk pool policies do provide a fairly comprehensive package of benefits. Unlike many private individual policies that do not cover physician fees, risk pools generally specify a minimum benefit package that includes in-patient hospital services and services rendered by or at the direction of a physician, as well as some skilled nursing care, home health care, and prescription drugs.

Normally a choice of deductibles is offered, ranging from as low as $150 to as high as $2000, resulting in substantially different premiums. Some form of pre-existing condition restriction has been deemed necessary, if only to prevent individuals from enrolling for insurance only after they need medical care. Most pools have a six to twelve month waiting period for pre-existing conditions. However, some states allow a waiver of this waiting period through payment of a premium surcharge.

COST OF INSURANCE

Cost remains the biggest barrier to obtaining health insurance through risk pools, since insurance provided to high risk individuals must obviously be more expensive than that for standard risks.

While these premiums are high, they would be even higher in the absence of state imposed limits that cap premiums at no more than a fixed percentage (usually about 150%) of the standard individual premium in the state.

One state has taken an additional step to make risk pools more accessible to the poor. The Wisconsin legislature in 1985 passed legislation appropriating funds to assist low income policyholders in paying premiums.

PAYING FOR THE POOL

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient, because of the premium cap and the poor health status of the insured individuals. Accordingly, the losses incurred are compensated by assessing the members of the pooling association, in proportion to their share of the state health insurance market. In most states, these pool assessments are subsidized through rebates on premium taxes or other state taxes.

Experience in most states indicates that the plans lose money over the course of a year. While losses can at times be large, the cost has been in the range of 1% of the total amount of premiums collected from all health insurance policies sold in those states.

Over the last couple of years, several other approaches to funding have become available. At least one state has decided to simply pay all losses directly out of state general funds, thereby foregoing the assessment totally. At least one other state has placed a tax on hospital patient revenues to raise the funds necessary to support operation of the program. There is no doubt that several other options will become available in the near future as more states consider the program.

IN SUMMARY

No one can reasonably claim that risk pools will solve the entire problem of the insured, since the reasons for this lack of coverage are enormously varied. Some people are left vulnerable by limitations in Medicaid eligibility; others are employed by firms that do not offer health insurance; still others are left without insurance after becoming unemployed or losing dependent coverage through a spouse; some take the risk of not purchasing insurance although they can afford it.

Risk pools represent a small step in reducing the uninsured population, or at least that segment of the insured that is not poor but could become poor when faced with major medical expenses. These plans, however, provide no comprehensive solution to the indigent care problem. Risk pools simply encourage and assist individuals in purchasing health insurance. Those who cannot afford to purchase insurance will in most cases not benefit from the pools.

ADDITIONAL INFORMATION

The remainder of this SLR contains information on specific state programs showing the status of legislation creating comprehensive health insurance pools and describing the main aspects of a particular state's pool.

NAIC MODEL LEGISLATION CREATING A STATE HEALTH INSURANCE POOLING MECHANISM

The final attachment to this SLR is the Model Legislation adopted by the National Association of Insurance Commissioners. Immediately preceding the NAIC Model is a brief synopsis of the model bill.

* * *

STATUS OF STATE LEGISLATION CREATING COMPREHENSIVE HEALTH INSURANCE POOLS FOR HIGH-RISK INDIVIDUALS

STATE	STATUS
ALASKA	Introduced in 1986 - Failed.
ARIZONA	Introduced in 1984 - Failed.
CALIFORNIA	Introduced in 1984, 1985, 1986 - Failed. Reintroduced in 1987.
COLORADO	Introduced in 1985, 1986 - Failed.
• **CONNECTICUT**	**Program in effect - 1976.**
• **FLORIDA**	**Program in effect - October, 1983.**
GEORGIA	Introduced in 1987 - Failed. Carryover to 1988 session.
• **ILLINOIS**	**Passed and signed into law, February, 1987. To become operational in 1988.**

•	**INDIANA**	**Program in effect - July, 1982.**
•	**IOWA**	**Program in effect - July, 1987.**
	KANSAS	Introduced in 1986 - Failed. To be reintroduced in 1988.
	KENTUCKY	Introduced in 1984 - Failed.
	LOUISIANA	Introduced in 1986, 1987 - Failed.
•	**MAINE**	**Passed into law - June, 1987. To become operational in 1988.**
	MARYLAND	Studied issue in 1986.
	MASSACHUSETTS	Studied issue in 1986.
•	**MINNESOTA**	**Program in effect - June, 1976.**
	MISSISSIPPI	Introduced in 1984, 1985, 1986, 1987 - Failed.
	MISSOURI	Introduced in 1984, 1985, 1986, 1987 - Failed.
•	**MONTANA**	**Passed and signed into law - 1985. To become operational in late 1987.**
•	**NEBRASKA**	**Program in effect - November, 1986.**
•	**NEW MEXICO**	**Passed and signed into law - April, 1987. To become operational in January, 1988.**
	NEW YORK	Introduced in 1985, 1986 - Failed. Reintroduced in 1987.
•	**NORTH DAKOTA**	**Program in effect - June, 1981.**
	OHIO	Introduced in 1983-84 and 1985-86 - Failed. Reintroduced in 1987.
•	**OREGON**	**Passed and signed into law - July, 1987. To become operational in 1988.**
	RHODE ISLAND	Catastrophic health plan in effect.
	SOUTH CAROLINA	Introduced in 1985-86 - Failed. Reintroduced in 1987 - Failed. Will carryover to 1988.
	SOUTH DAKOTA	Passed in 1984, but vetoed by Governor. Introduced in 1985, 1987 - Failed. Studying issue summer of 1987.
•	**TENNESSEE**	**Program in effect - July, 1987.**
	TEXAS	Introduced in 1977, 1987 - Failed.
	UTAH	Introduced in 1986 - Failed.
	VERMONT	Introduced in 1987 - Failed.

	VIRGINIA	Passed mandated enrollment for Blue Cross/Blue Shield in 1985. Studied pool issue in 1986.
•	**WASHINGTON**	**Passed and signed into law - May, 1987. To become operational in January, 1988.**
	WEST VIRGINIA	Introduced in 1987 - Failed.
•	**WISCONSIN**	**Program in effect - June, 1981.**

• **Highlighted states have existing plans.**

MAXIMUM LIFETIME BENEFITS PROVIDED

NOTE: The Maximum Lifetime Benefit Limitation is intended to limit the amount of coverage to be provided to the policyholder over the life of the insurance policy. To date, only one state has introduced legislation to deal with individuals reaching this limit. The wording on this legislation states that the plan may impose a premium surcharge and issue a new policy.

	STATE	STATUS
	ALASKA	No Limit In Legislation
	ARIZONA	$1,000,000 Lifetime Benefit
	CALIFORNIA	$1,000,000 Lifetime Benefit
	COLORADO	$500,000 Lifetime Benefit
•	**CONNECTICUT**	**$1,000,000 Lifetime Benefit**
•	**FLORIDA**	**$500,000 Lifetime Benefit**
	GEORGIA	$1,000,000 Lifetime Benefit
•	**ILLINOIS**	**$500,000 Lifetime Benefit**
•	**INDIANA**	**Plan I - No Limit** **Plan II - $50,000 Lifetime Benefit**
•	**IOWA**	**$250,000 Lifetime Benefit**
	KANSAS	No Limit In Legislation
	KENTUCKY	$1,000,000 Lifetime Benefit
	LOUISIANA	$500,000 Lifetime Benefit
•	**MAINE**	**Not Less Than $500,000 Lifetime Benefit**

•	**MINNESOTA**	**Regular Plan - $250,000 Lifetime Benefit** **Medicare Plan - $100,000 Lifetime Benefit**
	MISSISSIPPI	$500,000 Lifetime Maximum
	MISSOURI	$1,000,000 Lifetime Benefit
•	**MONTANA**	**Not Less Than $100,000 Lifetime Benefit**
•	**NEBRASKA**	**$500,000 Lifetime Benefit**
•	**NEW MEXICO**	**No Maximum Lifetime Benefit**
	NEW YORK	$500,000 Lifetime Benefit
•	**NORTH DAKOTA**	**$250,000 Lifetime Benefit**
	OHIO	$500,000 Lifetime Benefit
•	**OREGON**	**$1,000,000 Lifetime Benefit**
	SOUTH CAROLINA	$1,000,000 Lifetime Benefit
	SOUTH DAKOTA	$50,000 Annual - $250,000 Lifetime Benefit
•	**TENNESSEE**	**$500,000 Lifetime Benefit**
	TEXAS	$1,000,000 Lifetime Benefit
	UTAH	$250,000 Lifetime Benefit
	VERMONT	$250,000 Lifetime Benefit
•	**WASHINGTON**	**$500,000 Lifetime Benefit**
	WEST VIRGINIA	$1,000,000 Lifetime Benefit
•	**WISCONSIN**	**$500,000 Lifetime Benefit**

• Highlighted states have existing plans.

PREMIUM CAPS

NOTE: Most of the legislative proposals dealing with risk pools specify the maximum amount of premiums to be imposed on the policyholder. These premiums are generally arrived at by calculating the average individual standard rate charged by the five (5) largest insurers offering coverages in the state comparable to the pool coverage. This average is then raised by the appropriate limit specified in each state law. As an example, in a state where the premium cap is 150% and the average premium by the five largest insurers is $100, the maximum premium to be charged under the plan will be $150.

	STATE	**RATE**
	ALASKA	125% Maximum
	ARIZONA	150% Maximum
	CALIFORNIA	To Be Determined By The Board
	COLORADO	150% Initial, 200% Maximum
•	**CONNECTICUT**	**125% Minimum, 150% Maximum**
•	**FLORIDA**	**150% Initial, 200% Maximum**
	GEORGIA	125% Initial, 150% Maximum
•	**ILLINOIS**	**135% Maximum**
•	**INDIANA**	**150% Maximum**
•	**IOWA**	**150% Maximum**
	KANSAS	To Be Determined By The Board
	KENTUCKY	150% Initial, 200% Maximum
	LOUISIANA	135% Initial, 165% Maximum
•	**MAINE**	**150% Maximum**
•	**MINNESOTA**	**125% Maximum**
	MISSISSIPPI	150% Initial, 200% Maximum
	MISSOURI	150% Initial, 200% Maximum
•	**MONTANA**	**150% Initial, 400% Maximum**
•	**NEBRASKA**	**135% Initial, 165% Maximum**
•	**NEW MEXICO**	**150% Maximum**
	NEW YORK	150% Maximum
•	**NORTH DAKOTA**	**135% Maximum**
	OHIO	120% Initial, 175% Maximum
•	**OREGON**	**150% Initial Maximum**
	SOUTH CAROLINA	150% Initial, 200% Maximum
	SOUTH DAKOTA	125% Initial, 200% Maximum
•	**TENNESSEE**	**150% Maximum**
	TEXAS	150% Initial, 200% Maximum
	UTAH	To Be Determined By The Board

	VERMONT	135% Initial, 150% Maximum
•	**WASHINGTON**	**150% Maximum**
	WEST VIRGINIA	150% Maximum
•	**WISCONSIN**	**150% Maximum**

• Highlighted states have existing plans.

DEDUCTIBLES

NOTE: Many states offer more than one plan. Unless stated, the amounts listed are all deductibles available.

	STATE	AMOUNT
	ALASKA	To Be Determined By The Board
	ARIZONA	$200
	CALIFORNIA	$1,000
	COLORADO	$250; $500; $1,000 and any others Designated By the Board
•	**CONNECTICUT**	**$400; $1,000; $1,500**
•	**FLORIDA**	**$1,000 $1,500 $2,000**
	GEORGIA	$500; $1,500
•	**ILLINOIS**	**$250; $500; $1,000/Individual** **$500; $1,000; $1,500/Family**
•	**INDIANA**	**$200; $500; $1,000**
•	**IOWA**	**$500; $1,000 and any others Designated by The Board**
	KANSAS	To Be Determined By The Board
	KENTUCKY	To Be Determined By The Board
	LOUISIANA	To Be Determined By The Board
•	**MAINE**	**Not less than $500 nor more than $1,000**
•	**MINNESOTA**	**$500; $1,000**
	MISSISSIPPI	$1,000; $1,500; $2,000
	MISSOURI	To Be Determined By The Board

•	**MONTANA**	**Not to exceed $1,000**
•	**NEBRASKA**	**$250; $500; $1,000**
•	**NEW MEXICO**	**$500; $1,000**
	NEW YORK	$500; $1,000 and any othesr Designated by The Board
•	**NORTH DAKOTA**	**$150; $500; $1,000**
	OHIO	$500; $1,000 and any others Designated by The Board
•	**OREGON**	**To Be Determined By The Board**
	SOUTH CAROLINA	To Be Determined By The Board
	SOUTH DAKOTA	$500; $1,000 and any others Designated by The Board
•	**TENNESSEE**	**$500; $2,000 and any others Designated by The Board**
	TEXAS	To Be Determined By The Board
	UTAH	To Be Determined By The Board
	VERMONT	To Be Determined By The Board
•	**WASHINGTON**	**$500; $1,000**
	WEST VIRGINIA	$300; $1,000 and any others Designated by The Board
•	**WISCONSIN**	**$1,000**

*** Highlighted states have existing plans.**

STOP LOSS/OUT-OF POCKET EXPENSE LIMITATION

NOTE: Most state legislative drafts and existing plans require a co-insurance payment by the policyholder. This usually amounts to a 20% payment by the policyholder for all covered expenses once the deductible has been satisfied. However, most plans also provide for a stop loss limitation. What this means is that once the policyholder has paid the out-of-pocket expense limitation show here, the plan begins to pay 100% of eligible expenses during the year.

	STATE	AMOUNT
	ALASKA	To Be Determined By The Board.
	ARIZONA	$1,000/Individual; $2,000/Family
	CALIFORNIA	$3,000/Individual; $5,000/Family
	COLORADO	$1,500/Individual; $3,000/Family
•	**CONNECTICUT**	**$2,000/Individual; $4,000 Family**
•	**FLORIDA**	**Regular** Plan I $2,500/Individual; $5,000/Family Plan II $3,000/Individual; $6,000/Family Plan III $3,500/Individual; $7,000/Family **Medicare** Plan I $1,500/Individual; $5,000/Family Plan II $2,000/Individual; $6,000/Family Plan III $2,500/Individual; $7,000/Family
	GEORGIA	$3,500/Individual; $5,000/Family
•	**ILLINOIS**	**$1,500/INDIVIDUAL; $3,000/FAMILY; $500/MEDICARE**
•	**INDIANA**	**Plan I $1,000/Individual; $2,000/Family Plan II A. $1,000/Individual; $2,000/Family B. $1,500/Individual; $3,000/Family C. $2,000/Individual; $4,000/Family**
•	**IOWA**	**A. $1,500/Individual; $3,000/Family B. $2,000/Individual; $4,000/Family**
	KANSAS	To Be Determined By The Board.
	KENTUCKY	To Be Determined By The Board.
	LOUISIANA	To Be Determined By The Board.
•	**MAINE**	**Not to exceed $1,500/Individual; $3,000/Family**
•	**MINNESOTA**	**Regular Plan - $3,000 Individual Medicare Supplement - $1,000/Individual**
	MISSISSIPPI	$1,500/Individual; $3,000/Family; $500/Medicare
	MISSOURI	To Be Determined By The Board.
•	**MONTANA**	**$5,000/Individual**
•	**NEBRASKA**	**$5,000/Individual**
•	**NEW MEXICO**	**A. $1,500/Individual; $2,500/Family B. $2,000/Individual; $3,000/Family**
	NEW YORK	$1,500/Individual; $3,000/Family
•	**NORTH DAKOTA**	**$3,000/Individual**

	OHIO	$500/Deductible - $1,000/Individual; $3,000/Family $1,000 Deductible - $2,000/Individual; $4,000/Family
•	**OREGON**	**To Be Determined By The Board.**
	SOUTH CAROLINA	To Be Determined By The Board.
	SOUTH DAKOTA	$3,000/Individual; $6,000/Family
•	**TENNESSEE**	**A. $1,500/Individual; $2,000/Family** **B. $2,500/Individual; $3,500/Family**
	TEXAS	To Be Determined By The Board.
	UTAH	To Be Determined By The Board.
	VERMONT	To Be Determined By The Board.
•	**WASHINGTON**	**A. $1,500/Individual; $3,000/Family** **B. $2,500/Individual; $5,000/Family** **Medicare $1,000/Individual**
	WEST VIRGINIA	A. $1,300/Individual; $1,500/Family B. $2,500/Individual; $3,500/Family
•	**WISCONSIN**	**Plan I $2,000/Individual $4,000/Family** **Plan II $500/Individual $4,000/Family**

WAITING PERIOD FOR PRE-EXISTING CONDITION

NOTE: Most plans contain provisions under which coverage is excluded for a certain period of time following the effective date of coverage. This exclusion is based on a pre-existing condition which manifested itself within a certain period of time prior to coverage or medical advice or treatment was recommended or received.

Several states have expanded the pre-existing waiting period condition clause to cover other areas. One option being used by several drafts allows a waiver of this waiting period if the pre-existing condition exclusion has already been satisfied under any prior health insurance coverage which was involuntarily terminated and application for pool coverage is made not later than thirty days following the involuntary termination.

Also, one of the newest waivers allows an individual moving from one state plan to another first-day coverage if the waiting period had already been satisfied in the previous state. This is known as the reciprocity agreement.

STATE	**WAITING PERIOD**	**CONDITION PERIOD**
ALASKA	6 Months	6 Months
ARIZONA	6 Months	6 Months
CALIFORNIA	6 Months	6 Months

	COLORADO	6 Months	6 Months
•	**CONNECTICUT**	**12 Months**	**6 Months**
•	**FLORIDA**	**6 Months**	**6 Months**
	GEORGIA	12 Months	6 Months
•	**ILLINOIS**	**6 Months**	**6 Months**
•	**INDIANA**	**6 Months**	**6 Months**
•	**IOWA**	**6 Months**	**6 Months**
	KANSAS	To Be Determined By The Board	
	KENTUCKY	12 Months	6 Months
	LOUISIANA	6 Months	6 Months
•	**MAINE**	**90 Days**	**90 Days**
•	**MINNESOTA**	**6 Months**	**90 Days**
	MISSISSIPPI	12 Months	6 Months
	MISSOURI	12 Months	6 Months
•	**MONTANA**	**12 Months**	**5 Years**
•	**NEBRASKA**	**6 Months**	**6 Months**
•	**NEW MEXICO**	**6 Months**	**6 Months**
	NEW YORK	6 Months	6 Months
•	**NORTH DAKOTA**	**6 Months**	**90 Days**
	OHIO	6 Months	6 Months
•	**OREGON**	**6 Months**	**6 Months**
	SOUTH CAROLINA	6 Months	6 Months
	SOUTH DAKOTA	6 Months	6 Months
•	**TENNESSEE**	**6 Months**	**6 Months**
	TEXAS	12 Months	6 Months
	UTAH	12 Months	6 Months
	VERMONT	6 Months	6 Months
•	**WASHINGTON**	**6 Months**	**6 Months**
	WEST VIRGINIA	6 Months	6 Months
•	**WISCONSIN**	**6 Months**	**6 Months**

Compiled by Communicating for Agriculture

ELIGIBILITY CRITERIA

All states with a comprehensive health insurance plan, as well as those considering the program, have specific eligibility requirements for individuals wishing to take advantage of pool coverage.

Specific requirements for existing plans can be found by referring to state operational and plan summaries. However, the following is a look at the most common requirements.

1. **STATE RESIDENCY.** All individuals applying for pool coverage must be state residents. State legislation provides a range of residency requirements of 30 days up to six months before becoming eligible. Some states simply state "residents required" with no specific period listed.

2. **PROOF OF AT LEAST ONE OF THE FOLLOWING:**

   A. Proof of Rejection. Individuals must prove they have been rejected for similar health insurance coverage by at least one insurer. Some states require proof of rejection by more carriers, however the trend seems to be requirement of only one proof of rejection. In addition, several states are adopting or considering guidelines which allow for automatic acceptance into a pool. The pool Board adopts a list of medical conditions to allow automatic acceptance into the pool without requiring a proof of rejection if the individual is afflicted with one of these conditions.

   B. Presently Insured with a Higher Premium. An individual is eligible for pool coverage even though they are currently insured if their present insurance has a higher premium than that afforded under the pool.

   C. Presently Insured with a Rider or Rated Policy. An individual is eligible for pool coverage even though they are currently insured if their present insurance has a rider attached or is rated.

NON-ELIGIBILITY

Most state plans also list several non-eligibility criteria for individuals wishing to take advantage of the state pool. The most common areas specified in state legislation are the following:

1. **NON-RESIDENCY.** An individual is no longer eligible for pool coverage if they are no longer a resident of the state. However, some of the newest proposals being considered are adding a reciprocity agreement. This section states that when an individual moves from one state pool to another, and the individual had met all requirements of the previous state plan, immediate acceptance into the new pool will be granted upon payment of premium.

2. **ELIGIBLE FOR MEDICARE OR MEDICAID.** Many of the state plans do not allow an individual to apply for plan coverage if the individual is eligible for, or receiving, Medicare or Medicaid. However, several states have adopted a high-risk plan for Medicare or Medicaid eligible individuals.

3. TERMINATION OF COVERAGE. An individual is not eligible for plan coverage if he or she has terminated coverage in the pool unless twelve months have lapsed since such coverage.

4. EXTENDED LIFETIME BENEFIT. An individual is not eligible for plan coverage if he or she has reached the maximum lifetime benefit level authorized by the pool. However, several states have no lifetime benefit level in their plans, thereby negating this section. Also, one of the newer proposals being considered allows an individual to reapply for coverage with a premium surcharge for an extension of benefits.

5. INMATES. An individual is not eligible for plan coverage if he or she is an inmate of a public institution.

POOL FUNDING

NOTE: In theory, state health pools are designed to pay for themselves through premiums charged to the policyholders. However, due to the premium caps placed on all state pools and the fact that most individuals using the state plans are high risk, the pools will undoubtedly face a loss after paying out claims.

In the early years of state health pools, there were only a couple of options for paying this loss. However, in the last couple of years, several states have begun to explore alternative funding mechanisms.

Because of Federal Law (The Employment Retirement Income Security Act, known as ERISA) self-insurers are not required to become members of a state pool, therefore are not assessed any of the cost. In addition, all state pool legislation allows abatement of assessment if the payment of the assessment would endanger the ability of the member to fulfill his contractual obligations. Also, assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered.

	STATE	SOURCE
	ALASKA	Assessment of losses to participating insurers.
	ARIZONA	Assessment with credit applied against premium tax and income tax. Use formula of approximately 20% per year.
	CALIFORNIA	The state has created a start-up fund of $250,000. Future losses will be paid by taxes on employers.
	COLORADO	Assessment with credit applied against premium tax and income tax.
•	**CONNECTICUT**	**Assessment of losses to participating insurers.**
•	**FLORIDA**	**Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premiums or greater than premium tax. Use formula of approximately 20% per year for offset.**

GEORGIA	Assessment of losses to participating insurers.
* **ILLINOIS**	**The state will recoup any deficit incurred under the plan through appropriations made by The General Assembly.**
* **INDIANA**	**Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.**
* **IOWA**	**Assessment with credit applied against premium taxes, income taxes or revenue at the rate of 20% per year over a five-year period.**
KANSAS	To Be Determined By The Board.
LOUISIANA	Assessment with credit applied against premium tax.
* **MAINE**	**Assessment through a maximum .0015% tax on hospital patient service revenue.**
* **MINNESOTA**	**Assessment of losses to participating insurers. Prior to 1987, a tax credit was allowed towards the assessment.**
MISSISSIPPI	Assessment with credit applied against other taxes paid.
MISSOURI	Assessment with credit applied against premium tax.
* **MONTANA**	**Assessment with credit applied against premium tax.**
* **NEBRASKA**	**Assessment with credit applied against premium tax.**
* **NEW MEXICO**	**Assessment to participating insurers. A 30% credit will be allowed only on any amount exceeding $75,000 yearly.**
NEW YORK	Assessment of losses to participating insurers.
* **NORTH DAKOTA**	**Assessment with credit applied against premium tax and income tax.**
OHIO	Losses paid by state general funds.
* **OREGON**	**Assessment with credit applied against other taxes paid.**
SOUTH CAROLINA	Assessment with credit applied against premium tax and income tax.
SOUTH DAKOTA	Assessment with credit applied against premium tax. Use formula of approximately 20% per year write-off.

•	**TENNESSEE**	**Assessment of losses to participating insurers with credit applied against premium tax.**
	TEXAS	Assessment of losses to participating insurers.
	UTAH	To Be Determined.
	VERMONT	Assessment of losses to participating insurers.
•	**WASHINGTON**	**Assessment with credit applied against other taxes paid.**
	WEST VIRGINIA	Assessment with credit applied against premium tax.
•	**WISCONSIN**	**Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.**

*** Highlighted states have existing plans.**

AGENT & ADMINISTRATOR FEES

AGENT FEES: Agent fees are the dollar amount provided to a licensed insurance agent within a state for enrolling an individual in the state health plan. Several states spell out the amount within the statute, however most of the fees are set by the plan Board of Directors. Only those states with existing plans are shown here.

CONNECTICUT	**Agent Referral Fee - $20**
FLORIDA	**Agent Referral Fee - $75**
INDIANA	**Agent Referral Fee - $25**
IOWA	**Agent Referral Fee - $25**
MINNESOTA	**Agent Referral Fee - $50**
MONTANA	**Agent Referral Fee - $25**
NEBRASKA	**Agent Referral Fee - $25**
NORTH DAKOTA	**Agent Referral Fee - $25**
TENNESSEE	**Agent Referral Fee - $50**
WISCONSIN	**Agent Referral Fee - $35**

ADMINISTRATOR FEES: Administrator fees are the dollar amount provided to the carrier handling all administrative functions for the state plan. The administrator is usually awarded a contract for a period of three to five years to provide premium collection and benefit payments, as well as provide the Board with needed monitoring and data collection.

Most state plans provide for the Administrator to be paid out of either a percent of the premiums collected or a percent of the claims audited or paid. Much of this information can be obtained directly from the administrator, however the following states specifically spell out the maximum amount to be paid for administration of the plan.

MINNESOTA	**Administrator Fee - 12 1/2% of Premium Maximum**
MONTANA	**Administrator Fee - 12% of Premium Maximum**
NORTH DAKOTA	**Administrator Fee - 12 1/2% of Premium Maximum**

Compiled by Communicating for Agriculture
July, 1987

ELIGIBILITY CRITERIA

All states with comprehensive health insurance pools for high risk individuals, as well as those previously introducing legislation, have eligibility requirements for individuals wishing to take advantage of pool coverage.

The most common of these eligibility requirements are one or more of the following:

1. STATE RESIDENCY. All individuals applying for pool coverage must be state residents. This ranges from a residency requirement of 30 days up to six months before becoming eligible. Some states simply state "residency required" with no specific period listed.

2. PROOF OF REJECTION. Individuals must prove they have been rejected for insurance coverage by at least one insurance carrier. Some states require proof of rejection by at least two carriers, however the trend seems to be requiring only one proof of rejection. In addition, several states are adopting or considering guidelines which allow for automatic acceptance into a pool. The pool Board adopts a list of medical conditions to allow automatic acceptance into the pool without requiring a proof of rejection if the individual is afflicted with one of these conditions.

3. PRESENTLY INSURED WITH A HIGHER PREMIUM. An individual is eligible for pool coverage even though they are currently insured if their present insurance has a higher premium than that afforded under the pool.

4. PRESENTLY INSURED WITH A RIDER OR RATED POLICY. An individual is eligible for pool coverage even though they are currently insured if their present insurance has a rider attached or is rated.

5. Most states do not allow an individual to apply for pool coverage if that individual is eligible for Medicare or Medicaid. Several states do offer a Medicare supplement plan for these individuals.

SYNOPSIS OF MODEL

The purpose of the NAIC Model Bill is to estabish a mechanism through which dequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or pool in which all health care financing mechanisms (insurers, non-profit service plan corporations and HMOs) would be members.

The pool coverage consists of very broad, comprehensive benefits with a choice of "high" and "low" deductible. Each state is cautioned that the scope of coverage may not be appropriate. In such case the benefit levels should be adjusted.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial maximum rate of 150% of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience, however, in no event shall rates exceed 200% of standard risk rates. The initial maximum rate of 150% is admittedly inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the 200% maximum rate will be assessed to each member of the pool in proportion to the volume of business done in the state. Eligibility for pool coverage is not established by criteria such as the incurring of a catastrophic condition or the expenditure of a prescribed amount of earnings for health care. Such criteria may not apply equitably to all uninsurables and may neither be cost efficient nor practical to administer. Practical considerations of price will serve to discourage individuals from buying pool coverage when it is available to them in the standard marketplace at a lesser rate.

For obvious cost containment reasons, the pool coverage is the coverage of "last resort" and it does not duplicate coverages from any other source, private or public. The mechanics of the pool, its operations and functions must all be established under a plan approved by the Commissioner. The pool is subject to the requirements of the insurance code as has the general powers and authority of an insurer licensed to transact health insurance.

MODEL HEALTH INSURANCE POOLING MECHANISM ACT

Table of Contents

Section 1. Definitions
Section 2. Operation of Pool
Section 3. Eligibility
Section 4. Administrating Insurer
Section 5. Assessments
Section 6. Minimum Benefits - Availability
Section 7. Collective Action
Section 8. Taxation
Section 9. Effective Date

BE IT ENACTED BY THE STATE OF (insert state).
(adapt caption and formal portions to local requirements and statutes)

Statement of Principles

The State and Federal Health Insurance Legislative Programs (B6) Task Force was charged to develop model state legislation for the establishment of health insurance pooling mechanisms for uninsurables. The Task Force has developed the attached Model State Health Insurance Pooling Mechanism Bill and recommends its final adoption by NAIC subject to the following principles:

1. Adoption of the model bill does not constitute NAIC endorsement of the pooling concept, nor is it recommended for enactment in all states. Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective.

2. Enactment of the model bill by states is not recommended unless and until a viable solution is secured, through federal law or otherwise, under which pools for uninsurables can operate on a universal basis including all health care financing mechanisms. These recommendations and principles are consistent with NAIC strategy for alternatives to national health insurance which embrace the interrelated goals concerning the federal ERISA preemption problems, state pooling mechanisms, adequate health insurance availability and cost containment. The interrelationship of these initiatives is exemplified by the ERISA barrier to universal participation in such pools and overall concerns about health care cost containment.

Although much has been accomplished with the enactment of P.L. 97-473 subjecting multiple employer trusts to state jurisdiction, and by the adoption of the NAIC model "Jurisdiction to Determine Juridiction" bill, these measures will not, in and of themselves, establish universal participation in state pools for uninsurables.

Uninsurable pools may not be needed in every state, nor present the most effective answer to questions of availability of health insurance in every state. The establishment of such programs is costly and their cost effectiveness should be weighed in relation to whether there is a demonstrated need for a pool in a given state. Their cost effectiveness can be substantially impaired in the absence of universal participation, for without the inclusion of self-insured plans, the financial base necessary to support the pooling mechanism will tend to progressively diminish. The purpose of the attached model bill is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or pool in which all health care financing mechanisms (insurers, nonprofit service plan corporations, HMO's and self-insurers) would be members.

The pool coverage consists of very broad comprehensive benefits with a choice of a "high" and a "low" deductible. Each state is cautioned that the scope of coverage may not be appropriate. In such case, the benefit levels should be adjusted, or the bill should include the Alternative Section 6. under which the Commissioner is authorized to establish by regulation actual pool benefits commensurate with the prevailing levels of group coverages provided in that state.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial minimum rate of 150% of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience, however, in no event shall rates exceed 200% of standard risk rates. The minimum rate of 150% is admittedly inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the 200% maximum rate will be assessed to each member of the pool in proportion to the volume of business done in the state. Eligibility for pool coverage is not established by criteria such as the incurring of a catastrophic condition, the expenditure of a prescribed amount of earnings for health care, or the rejection of the applicant by any specified number of health insurance carriers. Such criteria may not apply equitably to all uninsurables and may neither be cost efficient nor practical to administer. Practical considerations of price will serve to discourage individuals from buying pool coverage when it is available to them in the standard marketplace at a lesser rate.

For the obvious cost containment reasons, the pool coverage is the coverage of "last resort" and it does not duplicate coverages from any other source, private or public. The mechanics of the pool, its operations and functions must all be established under a plan approved by the Commissioner. The pool is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to transact health insurance.

Section 1. Definitions.

(1) "Pool" means the State Health Insurance Pool as created in Section 2. of the Act.

(2) "Board" means the Board of Directors of the pool.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.

(4) "Insurer" means any insurance company authorized to transact health insurance business in this state, any (reference state nonprofit health care service plan act and, if appropriate, HMO law).

(5) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

(6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.

(8) "Physician" (reference applicable state laws).

(9) "Hospital" (reference applicable state laws).

(10) "Health maintenance organization" (reference applicable state laws).

(11) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to Section 3. of this Act.

(12) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to Section 6. of this Act.

(13) "Department" means the Insurance Department.

(14) "Commissioner" means the Insurance Commissioner.

(15) "Member" means all insurers and insurance arrangements participating in the pool.

Section 2. Operation of the Pool.

(1) There is hereby created a nonprofit entity to be known as the (State) Health Insurance Pool. All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after the effective date of this Act shall be members of the pool.

(2) The Commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. The pool members shall select the initial board of directors and appoint one or more insurers to serve as administrator. Both the selection of the board of directors and the administering insurer(s) shall be subject to approval by the Commissioner. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact health insurance and one domestic nonprofit health care service plan.

(3) If, within sixty (60) days of the organizational meeting, the board of directors is not selected or the administering insurer is not appointed, the Commissioner shall appoint the initial board and appoint an administering insurer.

(4) The pool shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Act must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

(5) In its plan the pool shall,

(a) Establish procedures for the handling and accounting of assets and monies of the pool.

(b) Select an administering insurer in accordance with Section 4. of this Act, and establish procedures for filling vacancies on the Board of Directors.

(c) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to Section 5. of this Act. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

(6) The pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under Section 1. and in addition thereto, the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

(e) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

(f) Issue policies of insurance in accordance with the requirements of this Act.

(g) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

Drafting Note - Optional Paragraph

A state may wish to provide members of the pool with the option of utilizing their existing distribution systems for the issuance of pool coverage. If so, such a provision should authorize the establishment of specific rules under which the pool would approve and serve as a reinsurer for coverage issued by members in their own names. Paragraph (h) is designed to allow states to implement this option.

(h) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Section 3. Eligibility.

(1) Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

(a) persons who have on the date of issue of coverage by the pool coverage under health insurance or an insurance arrangement;

(b) any person who is at the time of pool application eligible for health care benefits under (references state Medicaid law);

(c) any person having terminated coverage in the pool unless twelve months have lapsed since such termination;

(d) any person on whose behalf the pool has paid out $1,000,000 in benefits;

(e) inmates of public institutions and persons eligible for public programs.

(2) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

(3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Drafting Note - Section 3

It is intended that only those unable to purchase health insurance coverage in the marketplace at a reasonable price will apply for pool coverage. The higher cost of pool coverage should accomplish this result. However, to assure that the pool coverage does not compete with available coverage in the marketplace, a state may desire to include as a criterion for pool coverage the requirement of rejection of coverage by a specified number of health insurance carriers. This question is discussed fully in the attached Synopsis.

Section 4. Administering Insurer.

(1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual accident and health insurance;

(b) The efficiency of the insurer's claim paying procedures;

(c) An estimate of total charges for administering the plan;

(d) The insurer's ability to administer the pool in a cost efficient manner.

(2) (a) The administering insurer shall serve for a period of 3 years subject to removal for cause.

(b) At least 1 year prior to the expiration of each 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

(3) (a) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

(b) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

(c) The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

2. Evaluating the eligibility of each claim for payment by the pool.

(d) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Department on a form as prescribed by the Commissioner.

(f) The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

(1) Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(a) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and 110% of all claims paid by insurance arrangements in the state during the preceding calendar year.

(b) Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals 110% of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the Commissioner.

(2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred by not reported claims.

(3) (a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it.

(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this Section by the board among members.

(4) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this Section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for 4 years.

Drafting Note - Section 6

Section 6 deals with the coverage to be issued by the pool. The original draft bill established a comprehensive and specific plan of coverage. However, this plan may not be appropriate to the needs of all states. Thus, the model bill provides two alternative approaches to Section 6. Alternative 1 specifically establishes a broad, comprehensive plan of coverage in the form of a detailed schedule of benefits, exclusions, limits, deductibles and coinsurance factors.

Alternative 2 vests authority in the Commissioner to promulgate, with the advice and recommendations of the pool members, a level of pool coverage determined to be commensurate with those typically provided by a representational number of large employers in the state. It should be pointed out that most carriers will be members of the pools in more than one, and perhaps all, of the states that enacted pooling legislation. The administration of these pools will be greatly facilitated if those provisions of the model bill dealing with pool formation, operation and administration remain uniform. This uniformity will allow each state pool to benefit from the operational experience of the others and will facilitate monitoring of the efficiency of pooling mechanisms. There is not the same necessity, however, regarding the actual plan benefits or coverage and the scope of coverage could vary according to individual state needs.

ALTERNATIVE 1

Section 6. Minimum Benefits - Availability.

(1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4) (d) of this Section, up to a life time limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

(2) *Covered Expenses.* Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary:

(a) Hospital services;

(b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;

(c) Drugs requiring a physician's prescription;

(d) Services of a licensed skilled nursing facility for not more than 120 days during a policy year;

(e) Services of a home health agency up to a maximum of 270 services per year;

(f) Use of radium or other radioactive materials;

(g) Oxygen;

(h) Anesthetics;

(i) Prostheses other than dental;

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;

(k) Diagnostic x-rays and laboratory tests;

(l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(m) Services of a physical therapist;

(n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(o) Services for diagnosis and treatment of mental and nervous disorders, provided that an insured shall be required to make a 50 percent copayment, and that the payment of the pool shall not exceed $4,000 for outpatient psychiatric treatment.

(3) Exclusions. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(b) Care which is primarily for custodial or domicilliary purposes;

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred;

(g) Dental care except as provided in subsection (3) (l) of this section;

(h) Eyeglasses and hearing aids;

(i) Illness or injury due to acts of war;

(j) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year;

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(4) Premiums, Deductibles, and Coinsurance.

(a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(c) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standards risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

(d) The pool coverage defined in Section 6. shall provide optional deductibles of $500 or $1,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $3,500 per individual nor $5,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(5) Preexisting Conditions. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was termintated.

(6) Nonduplication of Benefits.

(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

(b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not coverage expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

ALTERNATIVE 2

Section 6. Minimum Benefits - Availability.

(1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, shall be established through regulations promulgated by the Commissioner taking into consideration the advice and recommendations of the pool members.

(2) In establishing the pool coverage, the Commissioner shall take into consideration the levels of health insurance provided in the state, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(3) Pool coverage established under this Section shall provide both an appropriate "high" and a "low" deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(4) Premiums and Assessments.

(a) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

(b) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

(5) Preexisting Conditions. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

(6) Nonduplication of Benefits.

(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

(b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

Section 7. Collective Action.

Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

Section 8. Taxation.

The pool established pursuant to this Act shall be exempt from any and all taxes.

Drafting Note - Optional Section

A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the members of the pool. If so, such a provision should allow appropriate reductions in assessments as to pool members not subject to the taxes against which offsets are allowed.

Section 9. Effective Date.

The provisions of this Act shall become effective____________________________________

Legislative History (all references are to the Proceedings of the NAIC)

1983 Proc. II 16, 22, 638, 693, 698-712 (adopted).
1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance Act of 1983 as NAIC Policy)

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: ______________________________

Address ______________________________

Represen

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I invite … to submit your
written

Dear Senator Riegle;

Thank you for your letter regarding health care, I too believe all American needs it.

I have Blue Cross Blue Care, am going to have to drop it as $94.94 out of my S.S. + small pension is getting to much to handle.

My only answer is to make sure Medicare + Medicaid cover low income, Seniors and Handi-capped are covered

Thank You
Mrs Jean Rankin
500 E. Nine Mile Rd apt 202
Ferndale, Mi 48220

REGION VII AREA AGENCY ON AGING

EUGENE HARANDA, CHAIRMAN
MOHAMMED KHAN, EXEC. DIRECTOR

MEMBER COUNTIES: BAY ■ CLARE ■ GLADWIN ■ GRATIOT ■ HURON ■ ISABELLA ■ MIDLAND ■ SAGINAW ■ SANILAC ■ TUSCOLA

July 7, 1989

The Honorable Donald Riegle
State Senator
700 Washington Square Building
109 W. Michigan Avenue
Lansing, MI 48933

Dear Senator Riegle:

Thank you for the opportunity to submit written testimony on the problems of access to health care for uninsured persons. My name is Mohammed Khan. I am the Executive Director of the Region VII Area Agency on Aging, which serves the ten-county area comprised of Saginaw, Bay, Midland, Isabella, Clare, Gladwin, Gratiot, Huron, Tuscola and Sanilac. In recent years we have become increasingly aware of the problems encountered by persons who do not have health care insurance. In addition to the many individuals who have contacted us directly for assistance with problems relating to lack of insurance, the difficulties of the uninsured have come to our attention through the programs that our agency administers.

For example, Region VII administers the Title V Senior Community Service Employment Program. This program provides employment and training opportunities for low income persons age 55 and older. In order to qualify for this program, participants' income cannot exceed 125% of the poverty level. We have found that as a consequence of limited income, the overwhelming majority of these people do not have health insurance! Yet their income and assets exceed the limits for Medicaid eligibility.

Of the 66 Title V positions administered through our agency, fifty-five individuals, or 83% of this program's participants are without health insurance. This is especially significant in light of the fact that these individuals have the option to participate in the Region VII's health insurance plan. As a benefit of their part-time employment/training status, Region VII will pay one-half of the monthly insurance premium, with the participant contributing the balance. Only 11 individuals chose to receive this benefit and participate in the health insurance plan!

Mr. P. is a Title V enrollee. He turned 62 this year. Four years ago, he suffered a massive health attack. At the time he carried no health insurance, yet his income was too high to qualify for Medicaid.

While he recovered physically and is now able to return to work, his financial recovery was not as complete. Mr. P. is currently faced with $10,000 in outstanding medical bills.

Another uninsured Title V enrollee became gravely ill and almost died about a year ago. She delayed appropriate medical attention and treatment for an infection. She consequently developed sepsis, a toxic condition resulting from the spread of bacteria, which seriously threatened her life. Had she had the peace of mind of adequate health insurance protection, she would not have risked her life by delaying necessary treatment.

In Gratiot County, a 76-year old widow developed severe edema. Medical treatment was not obtained until recently, when her leg burst open. She was subsequently hospitalized, but her leg is now infected and she is faced with the possibility of amputation. This individual is not eligible for Medicare. Her late husband was a postal worker. Upon his retirement, he failed to choose the option of carrying health insurance for himself and his spouse. His widow is now among those who fall between the cracks of Medicare and Medicaid. Her limited income and lack of knowledge about health insurance places her in the ranks of the uninsured. She now risks losing not only her leg but also her assets in order to qualify for Medicaid.

A few months ago, our agency received a telephone call from Mrs. B., 63-year old woman whose divorce from her husband of 40+ years was about to be finalized. Her husband is a retired school teacher and enjoyed the benefits of a comprehensive health insurance plan provided through the retired school teachers' association. As part of the divorce settlement, the husband was terminating payment of the health insurance premium for his wife. Mrs. B. was not eligible for continuation in the plan under the COBRA legislation because the plan is administered by a retirees' group. Mrs. B. was worried about her ability to pay for individual, non-group health insurance. She was also concerned about the cost of her medications, previously picked up under her husband's plan. Her medication expenses alone were running over $100 per month. We are concerned about her protection during the transition period from a group plan to an individual plan, particularly as it relates to exclusions for pre-existing conditions.

Several other cases involving individuals without health insurance could be cited here. Many of these people have been lucky. They took a chance, and simple have not as yet required costly hospitalization or medical treatment. But they constantly live with the fear of bankruptcy and impoverishment if their health should take a turn for the worse.

The Region VII Area Agency on Aging urges the development of a comprehensive national health insurance policy that assures each and every American access to our society's health care delivery system. We appreciate your interest and support for the issue of concern that affects significant numbers of elderly persons.

Sincerely,

Mohammed Khan
Executive Director

MK/JS/jm

Paw Paw, Mich
June 23, 1984

Senator Donald W. Riegle Jr
705 Washington Square Building
109 W. Michigan Ave.
Lansing, Michigan 48933

Dear Senator Riegle.

I received your letter concerning your Senate Finance Subcommittee hearing on the problem of access to health care for uninsured individuals but made a mistake and sent it to Washington, D.C. Office.

I don't know the answer to the dilema but if individuals are taxed for it please make it so everybody pays for it not just industry, because industry already has workmans Compensation and I realize that's only for the worker but we in agriculture have never been able to pass our increased cost on to consumers like other industries such as automakers or Upjohn Co does and we all know how much automobiles, parts and machine costs have increased and the people who work there get a much higher salary and have had "costs of living increases" which has never applied to farmers for their products

Page 4

[illegible] [illegible] food [illegible] [illegible] want [illegible] [illegible]
food enough from the [illegible] next.

[illegible] [illegible] [illegible] [illegible] time 3 35 Insurance
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[illegible] [illegible] the employee wants to keep
him, we have so many people who want to
start at top of [illegible] [illegible] and [illegible]
[illegible] [illegible] good work habits, Executive are a
[illegible] [illegible] They all want big time jobs
without experience and no insurance [illegible] are
so [illegible] we can't give them that experience

I also think when people apply for government
fund, they should be tested for drugs as in the
past we have had experience and think our tax
dollars supports the drug habit.

In many cases people who don't have a steady
job are heavy drinkers or [illegible] smokers so
eventually our health insurance will skyrocket
even more and we the tax payers will foot the
bill, just like the [illegible] [illegible]. along
with some [illegible] people [illegible] [illegible]
to increase greatly. to be Social Security [illegible]
[illegible] the program [illegible] for
to many more than [illegible]

I [illegible] appreciate government making everyone
pay for insurance for anyone whose lifestyle has been
[illegible] in the past.

Sincerely,
[illegible] Richardson

RIFENBERG AGENCY, INC.

721 EAST MAIN STREET – NILES, MICHIGAN 49120 – 683-6700

Oliver W. Scott
Paul E. Rifenberg
Barry T. Pawielski

June 21, 1989

The Hon. Donald W. Riegle Jr.
U.S. Senate
700 Washington Square Bldg.
109 W. Michigan Ave.
Lansing, MI 48933

Dear Senator Riegle:

Thank you for you letter of 6/5/89 concerning the Senate Finance Subcommitte hearing on 6/28/89. Per your invitation, I would desire that this letter be entered as written testimony in the public record as to my views on the subject of federal health programs.

I believe that I speak for most Americans when I say that we desire less government intervention in our lives, not more. The prospects of a federally mandated, federally subsidized national health insurance plan, with all the accompaning bureaucratic inefficiencies and waste that would surely follow... is counter to that basic desire. If you and your colleagues are asking me whether it's okay to tell those several million uninsured Americans... "We're from the government and we're here to help you," then I must decline, because there are two hundred million or so other Americans who have utilized our free enterprise system to acquire adequate health coverage. They should not have to bear the burden of another bloated give-away from Washington.

It is my opinion that any form of "help" you ultimately choose to provide should be channeled through the private insurance industry. If you can maintain a level of competition, as there exists today, it will be to all our advantage. To exclude the private sector, even partially, would be wrong and counterproductive. It might also create more uninsured workers for you to deal with.

It is my opinion that a comprehensive study of the socialized program in Canada and Europe be made so that we might learn from their mistakes and benefit from their strong points. The "wheel need not be re-created" in this country.

Finally, we should look carefully at the possibility of expanding the existing programs, like medicaid, to cover those who don't currently qualify.

Thank you for this opportunity. Please don't forget our live prisoners of war in Southeast Asia.

Respectfully,

Paul E. Rifenberg

Paul E. Rifenberg, ~~CLU~~, ChFC
President
RIFENBERG AGENCY, INC.

PER/lks

RPO FINANCIAL SERVICES

Ronald P. Omtvedt • Registered Representative of Mutual Service Corporation • Member, NASD/SIPC

June 26, 1989

Senator Donald W. Riegle, Jr.
700 Washington Square Bldg.
109 W. Michigan Ave.
Lansing, Michigan 48933

Dear Senator Riegle:

Thank you for your invitation to attend the Senate Subcommittee hearing, to be held on June 28, 1989. Per your letter, I would like to submit the following testimony.

My testimony comes from five different perspectives, which I feel qualifies me to provide valid input.

I am an independent insurance agent with fifteen years experience. For the last twelve years I have specialized in providing Major Medical coverages to individuals and to small groups with one to fifty employees. We provide a research service from our database of over two hundred plans, to our clients and over one hundred other insurance agents. I am enclosing a sample for your reference.

Secondly, I am a businessman and employer and face the day to day problems, regulations, and spiraling overhead that all businesses must deal with.

Thirdly, I am a diabetic. I was diagnosed thirteen years ago, controlled with daily insulin and fortunately have had no problems or medical expenses (other than medication and occasional check-ups), in that time. However, due to this condition my options for medical coverage are extremely limited, despite the fact that I have the advantage of knowing what is available. This situation makes me aware of the dilemma of thousands of Americans across the country, unable to get coverage at any cost, due to a "pre-existing condition".

FOURTH, my wife has been a Registered Nurse in a neo-natal intensive care unit at a large well known university hospital for many years. This hospital has the latest in diagnostic equipment and is considered to be among the finest treatment facilities available, with billing practices to match. We are aware of countless situations of indigent mothers and their babies being patients at this facility. Many of these babies would accumulate accounts that would run into hundreds of thousands of dollars if billed to private insurance carriers. These patients were without insurance and did have access to the finest health care available. It is questionable as to whether a so called "middle class" employed family would have this same access without insurance.

The point is that the needy do have access to quality health care and in some cases they may have better access than the owners or employees of small firms.

My final perspective comes from that of a taxpayer. Although this seems to be obvious and most of us consider ourselves to be taxpayers, it is a cause of great concern. If the Federal Government intends to get involved in the health care provider system, Congress should first look at the track record. Social Security is operating on a hand to mouth system, without proper actuarial reserves. The majority of middle aged and younger Americans I've talked to, don't believe they will ever collect Social Security. Every time congress raises the contribution rate to bail out the system, they sweeten the recipients benefits, which is self defeating.

Medicare is a sad joke. The Medicare allowed charges are in many cases less than the provider charges. The excess is being billed to our elder Americans or cost-shifted to privately insured individuals. Furthermore, the Federal Government has shifted its responsibility for Medicare as primary coverage to employers with employees over age 65. Where is the Government going to shift this cost with any form of Government sponsored plan?. Medicare fraud is a problem that we read about too often.
We hear about ridiculous charges for hammers and toilet seats in the defense budget. Will we hear about two hundred dollar asprin tablets if the government gets involved in some sort of national health care program? The Federal Governments track record is not very good in these areas. These programs are much simpler to administer than any form of national health program.

We have a major problem to deal with in the health care delivery system. It will take some co-operation on the part of the insurance industry, medical providers, legal system, and the Government.

I feel the insurance industry must respond with a method of providing coverage to otherwise excluded individuals or groups through a special risk pool, if necessary. Rate adjustments should be spread equally across the whole block of business, as opposed to tier rating for small businesses thereby forcing out of coverage when they have a claim.

Hospitals must be made to be more accountable in their waste, overbuilding. There could be more sharing of expensive diagnostic equipment. There is no justification for non-profit hospitals spending large sums of money for advertising, a widely spread practice in recent years. Hospitals and clinics could receive a subsidy for treatment of indigent patients. They should forfeit there non-profit status if found guilty of medicare fraud or repeated practices of overbilling insurers.

The cost of educating new doctors and other medical personnel is staggering. There are rumors of large unpaid student loans. Perhaps educations could be subsidized in return for a mandatory period of service (similar to armed service for R.O.T.C.),. to treat the needy in government clinics (similar to V.A. hospitals).

There must be some caps put on mal-practice and personal injury lawsuits. There is no amount of money that will replace a person or their ability to perform a specific or potential job. However, the runaway settlement cost are being paid by all of us through higher medical cost and insurance premiums.

The Government can be effective in policing providers that are negligent or abusing the system, by revoking licenses or non-profit status. By subsiding educations in return for service as previously mentioned. I believe that tax credits are far more effective as an inducement for businesses to provide available health insurance programs to employees, than tax penalties. My experience indicates that many employers are dropping sponsored group plans due to the complexity of Section 89, a self-defeating concept. The Government should not attempt to provide a national sponsored health insurance or mandated program. It would be the most abused, inflationary, situation in the history of this country and would necessitate a tax rate that destroy the country.

Sincerely,

Ronald P. Omtvedt

A COMPARATIVE
GROUP HEALTH INSURANCE REPORT

for

SAMPLE CASE COMPANY

Prepared by:

PROFESSIONAL AGENTS

Through:

RPO FINANCIAL SERVICES

This report is to be used for comparative purposes only. While we believe the rates and information herein to be accurate, final rates, benefits and group acceptability will be determined at the time of enrollment by the underwriting carrier. No warranties are made regarding rates, underwriting requirements, transfer benefits nor industry acceptability. The agent or broker assumes final responsibility for all information presented. Particular care should be exercised when discussing: 1) industry eligibility, 2) takeover benefits, and 3) underwriting requirements. In no event should in-force coverage be terminated until acceptance of the group has been received!

Explanatory notes and definitions

The following terms are defined to provide improved understanding of this report:

1. UNDERWRITING: The information required by the insurance company to determine the acceptability of the risk to be insured. Health statements as well as other risk factors are considered. The following classifications are used in this report:

   a) GUAR ISSUE - No health questions are asked. Acceptance subject to approval.
   b) NON-MEDICAL - No medical questions are asked on either the enrollment cards (except for height & weight) or on the Master Application.
   c) MASTER APP - Health questions are asked only on the Master Application.
   d) SIMP ACCEP - A limited of number health history questions are asked on the Master application and/or the Individual Enrollment Cards.
   e) FULL MEDICAL - Complete health history questionnaire on each applicant is required.

2. PRE-EXISTING CONDITIONS: Refers to health condition(s) that a person has prior to becoming insured under the plan. Notations used in this report are: X prior - Y free - Z under plan. 'X' represents the period of time, in months, used to define a pre-existing condition. 'Y' is the number of months a person must go 'treatment free' and 'Z' is the required number of months of coverage under the plan ('Y' and 'Z' define when a pre-existing condition will be covered). Pregnancy may be handled differently than other pre-existing conditions.

3. TAKEOVER BENEFITS: When replacing health coverage, careful consideration must be given to pre-existing conditions. Be sure that you understand the benefits provided by the selected carrier and note that pregnancy is often treated differently when replacing existing coverage. Takeover benefits are classified as follows:

   a) NONE: No takeover benefits provided. Pre-ex waiting periods are required before any benefits are provided for pre-existing conditions.
   b) MAXIMUM $X,XXX: Limited takeover benefits. Some plans pay specific maximum dollar benefits for pre-existing conditions. '$X,XXX' indicates amount payable.
   c) TRANSFER OF COVERAGE: The new plan provides SOME HIGHER LEVEL of coverage for employees with pre-existing conditions insured under the prior plan . Completing "waiting periods" under the prior plan may be required. "No loss / No gain" and Continuity of Coverage are other terms for Transfer of Coverage.

4. INDUSTRY: This report screens more than 150 industry classifications for each carrier. Verification of industry eligibility with each carrier is recommended.

5. SUPPLEMENTAL ACCIDENT: Plan must provide at least a 'deductible waiver ' for accidents.

6. BEST RATING: An objective financial analysis by A.M. BEST Co. providing an assessment of 'relative financial strength' of the various insuring companies. Insuring companies are classified on a scale of 'A+' through 'C'. An additional 'financial size category' indicates the relative financial size of the various insurance companies analyzed. A Roman numeral designation of 'I' (lowest) to 'XV' (highest) is assigned.

7. SWING PLAN: Major medical plan with a PPO or HMO option with different benefit levels.

8. SPLIT DEDUCTIBLE: Used to define plans that require separate deductibles for out-patient versus in-patient benefits.

9. INDIVIDUAL PLAN: Individually underwritten product for one or more lives that may or may not be list billed. Generally does not need to satisfy the employee/employer relationship requirement of most METs.

10. TEFRA/COBRA: In groups of 20 or more employees you should know and secure additional information about special plan options available for insureds age 65 and over and be aware of employer obligations related to continuation benefits for certain terminating employees. Most companies have not released rate adjustments for groups with COBRA employees. If your group has a COBRA employee you must check with the underwriting carrier for the proper rates.

Summary of Employee Census Information
for
SAMPLE CASE COMPANY

#	Employee	Sex	Age	Coverage	# of Child	Smoker	Annual Income	Class
1	K. GIBSON	M	29	Family	1	no	n/a	other
2	L. EVANS	F	44	Employee & spouse	0	no	n/a	other
3	B. WILLIS	M	39	Employee & child(ren)	1	yes	n/a	other
4	M. JACKSON	M	26	Employee only	0	no	n/a	other
5	T. SELEK	M	38	Family	2	no	n/a	other
6	T. CRUISE	M	24	Employee & spouse	0	no	n/a	other
7	W. HOUSTON	F	24	Employee only	0	yes	n/a	other

Plan specifications requested:

Deductible range: $0-$300
Maternity : Required
Dental : No
Supp. accident : No
Rx card : No
Vision : No
Weekly income : No
24 hour cov'g : No
Dependent life : Not Acc

Underwriting : Full Med
Takeover : None
Rate guarantee: None
BEST rating : B or higher
Split deduct : Acceptable
R&B limit plan: Not Accept
Minimum Co-pay: 70%
Max stop loss : All plans

Comp. Major Med : Accept
Pref Provider Org: Accept
Health Maint Org : Accept
Blue Cross/Shield: Accept
Swing Plan : Accept
Individual Plan : Accept
In-hospital only : Accept

Industry: Florist, gift shops (SIC# 595)
County : Oakland
City : n/a

Zip code : 48018
# related employees: 0

Census: 2
Prep Date: 06/27/89
Eff Date: 07/01/89

Note: Detail pages illustrate plans meeting the above plan specifications.
Only plans meeting above specs are illustrated on cost ranking pages.

Listing of trusts with
PENDING RATE or PLAN CHANGES

Trust name	Anticipated date of change	Estimated change
Ambassador	09/01/89	Not provided
EGIS	07/01/89	Not provided
Guard'n MI	06/01/89	Not provided
National Group Trust	07/01/89	Not provided
RITE	08/01/89	Not provided

Notes: 1) Information on changes are based upon periodic inquiries to the respective trusts and should only be considered an ESTIMATE.

2) Trusts are listed above if the anticipated date of rate change is either prior to or within 90 days of the effective date for the case.

Group Health Insurance Cost Analysis

for

SAMPLE CASE COMPANY

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Pan American Life Ben-E-Med Basic DD	A+	S ?	$250 Major Med.	70% $5,000	Full Medical Max $1,500	6 months	$904.51
Congress/Security Life BEST 2+ In-Hosp CC	B+		$250 MajMed in H	80% $5,000	Guar Issue None	6 months	$917.76
Pan American Life Ben-E-Med Standard DD	A+	S ?	$250 Major Med.	80% $5,000	Full Medical Max $1,500	6 months	$970.73
Congress/Security Life BEST 2+ In-Hosp CC	B+		$100 MajMed in H	80% $5,000	Guar Issue None	6 months	$980.00
Pan American Life Ben-E-Med Basic	A+	?	$250 Major Med.	70% $5,000	Full Medical Max $1,500	6 months	$981.40
Pan American Life Ben-E-Med Superior DD	A+	S ?	$250 Major Med.	80% $2,500	Full Medical Max $1,500	6 months	$1,033.51
Pan American Life Ben-E-Med Basic DD	A+	S ?	$100 Major Med.	70% $5,000	Full Medical Max $1,500	6 months	$1,045.91
Pan American Life Ben-E-Med Standard	A+	?	$250 Major Med.	80% $5,000	Full Medical Max $1,500	6 months	$1,053.29
Pan American Life Ben-E-Med Basic	A+	?	$100 Major Med.	70% $5,000	Full Medical Max $1,500	6 months	$1,074.91
Pan American Life Ben-E-Med Standard DD	A+	S ?	$100 Major Med.	80% $5,000	Full Medical Max $1,500	6 months	$1,122.91
Pan American Life Ben-E-Med Superior	A+	?	$250 Major Med.	80% $2,500	Full Medical Max $1,500	6 months	$1,124.27
Benefit Trust Life Ins. Med*Star * S3/S4	A		$250 Major Med.	80% $5,000	Full Medical Max $2,000	6 months	$1,128.40
Garden State Life Ins. Amer Emp Pl 12 - UR	A		$250 Major Med.	80% $5,000	Full Medical Max $3,000	6 months	$1,140.50
Pan American Life Ben-E-Med Standard	A+	?	$100 Major Med.	80% $5,000	Full Medical Max $1,500	6 months	$1,153.91
Congress/Security Life BEST 2+ Comp CC	B+		$250 Major Med.	80% $5,000	Guar Issue None	6 months	$1,157.88
Amer. Community Mutual PEP I $5,000	A		$250 Major Med.	80% $5,000	Full Medical None	12 months	$1,166.93
Benefit Trust Life Ins. Med*Star P2	A		$250 Swing Plan	80% $5,000	Full Medical Max $2,000	6 months	$1,173.40

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Benefit Trust Life Ins. Med*Star * S3/S4	A		$150 Major Med.	80% $5,000	Full Medical Max $2,000	6 months	$1,187.40
Amer. Community Mutual PEP II $3,500	A		$250 Major Med.	80% $3,500	Full Medical None	12 months	$1,195.61
Pan American Life Ben-E-Med Superior DD	A+	S ?	$100 Major Med.	80% $2,500	Full Medical Max $1,500	6 months	$1,195.91
Acceleration Life Ins Co RITE PC $5,000	B+		$0 Major Med.	70% $5,000	Full Medical Max $3,000	None	$1,196.43
Hartford Life & Accident AnchorPlan Revue	B+		$250 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,218.00
Garden State Life Ins. Amer Emp Pl 12	A		$250 Major Med.	80% $5,000	Full Medical Max $3,000	6 months	$1,227.79
Garden State Life Ins. Amer Emp Pl 12 - UR	A		$250 Major Med.	80% $2,000	Full Medical Max $3,000	6 months	$1,227.79
Pan American Life Ben-E-Med Superior	A+	?	$100 Major Med.	80% $2,500	Full Medical Max $1,500	6 months	$1,231.91
Congress/Security Life BEST 2+ Comp CC	B+		$100 Major Med.	80% $5,000	Guar Issue None	6 months	$1,241.00
Benefit Trust Life Ins. Med*Star Class 2	A		$250 Major Med.	80% $5,000	Full Medical Transfer Covg	6 months	$1,247.40
Hartford Life & Accident AnchorPlan	B+		$250 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,260.00
Benefit Trust Life Ins. Med*Star Star S2	A		$150 Major Med.	80% $2,500	Full Medical Max $2,000	6 months	$1,269.40
Hartford Life & Accident AnchorPlan Revue	B+		$150 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,270.00
Amer. Community Mutual PEP I $5,000	A		$100 Major Med.	80% $5,000	Full Medical None	12 months	$1,278.09
Central Reserve Life Simplicity+ $250	B+		$250 Major Med.	80% $4,000	Full Medical Max $3,000	12 months	$1,279.00
Benefit Trust Life Ins. Med*Star Class 5	A		$100 Major Med.	80% $5,000	Full Medical Transfer Covg	6 months	$1,280.40
Garden State Life Ins. Amer Emp Pl 11 - UR	A		$100 Major Med.	80% $5,000	Full Medical Max $3,000	6 months	$1,289.30
Benefit Trust Life Ins. Med*Star P1	A		$100 Swing Plan	80% $5,000	Full Medical Max $2,000	6 months	$1,289.40
Central Life Assurance CLIENT C/A 250(7500)	A+	?	$250 Major Med.	80% $7,500	Full Medical Max $1,000	12 months	$1,293.15

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Acceleration Life Ins Co RITE PC $2,500	B+		$0 Major Med.	70% $2,500	Full Medical Max $3,000	None	$1,294.60
Acceleration Life Ins Co RITE Plan A	B+		$250 Major Med.	80% $5,000	Full Medical Max $3,000	None	$1,294.60
Amer. Community Mutual PEP II $3,500	A		$100 Major Med.	80% $3,500	Full Medical None	12 months	$1,309.55
Hartford Life & Accident AnchorPlan	B+		$150 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,313.00
Central Life Assurance CLIENT C/A 250(5000)	A+	?	$250 Major Med.	80% $5,000	Full Medical Max $1,000	12 months	$1,319.98
Garden State Life Ins. Amer Emp Pl 12	A		$250 Major Med.	80% $2,000	Full Medical Max $3,000	6 months	$1,322.09
Washington National The Leader Plan C	A+		$250 Ind Maj Med	80% $10,000	Full Medical None	6 months	$1,339.40
Hartford Life & Accident AnchorPlan Revue	B+		$100 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,345.00
Central Life Assurance CLIENT Pln 250(7500)	A+	?	$250 Major Med.	80% $7,500	Full Medical Max $1,000	12 months	$1,355.07
Acceleration Life Ins Co RITE Plan A	B+		$250 Major Med.	80% $3,000	Full Medical Max $3,000	None	$1,359.21
Benefit Trust Life Ins. Med*Star Class 1	A		$100 Major Med.	80% $5,000	Full Medical Transfer Covg	6 months	$1.366.40
Central Life Assurance CLIENT C/A 250(2500)	A+	?	$250 Major Med.	80% $2,500	Full Medical Max $1,000	12 months	$1,374.95
Central Reserve Life Simplicity+ $100	B+		$100 Major Med.	80% $4,000	Full Medical Max $3,000	12 months	$1,377.00
Crown Life Insurance Co. Crown Life Gem Plan 2	A+		$250 Major Med.	80% $5,000	Full Medical Max $2,000	6 months	$1,380.10
Central Life Assurance CLIENT Pln 250(5000)	A+	?	$250 Major Med.	80% $5,000	Full Medical Max $1,000	12 months	$1,383.23
Garden State Life Ins. Amer Emp Plan 11	A		$100 Major Med.	80% $5,000	Full Medical Max $3,000	6 months	$1,388.50
Garden State Life Ins. Amer Emp Pl 11 - UR	A		$100 Major Med.	80% $2,000	Full Medical Max $3,000	6 months	$1,388.50
Hartford Life & Accident AnchorPlan	B+		$100 Major Med.	80% $5,000	Full Medical Max $1,000	None	$1,394.00
Acceleration Life Ins Co RITE PC $3,000	B+		$0 Major Med.	80% $3,000	Full Medical Max $3,000	None	$1,400.77

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Central Life Assurance CLIENT C/A 150(7500)	A+	?	$150 Major Med.	80% $7,500	Full Medical Max $1,000	12 months	$1,404.95
Central Life Assurance CLIENT Pln 250(3500)	A+	?	$250 Major Med.	80% $3,500	Full Medical Max $1,000	12 months	$1,411.40
Pacific Mutual Life PM - MPT Plan	A+	?	$300 Major Med.	80% $5,000	Full Medical Transfer Covg	12 months	$1,412.27
NN Investors/Pac. Fid. Cost Saver Pre-Cert	A		$250 Major Med.	80% $5,000	Master App Max $500	6 months	$1,418.02
Time Insurance Company SigMET $250 ($5,000)	A+		$250 Major Med.	80% $5,000	Full Medical Max $2,000	12 months	$1,420.50
Central Reserve Life Simplicity+ 1st $	B+		$250 Major Med.	80% $2,000	Full Medical Max $3,000	12 months	$1,423.00
Central Life Assurance CLIENT C/A 150(5000)	A+	?	$150 Major Med.	80% $5,000	Full Medical Max $1,000	12 months	$1,434.20
Provident Mutual Life NET Comp $100/250 $7.5	A+		$250 Major Med.	80% $7,500	Full Medical Max $1,000	6 months	$1,435.38
Central Life Assurance CLIENT Pln 250(2500)	A+	?	$250 Major Med.	80% $2,500	Full Medical Max $1,000	12 months	$1,440.93
Washington National The Leader Plan A	A+		$250 Ind Maj Med	80% $5,000	Full Medical None	6 months	$1,441.88
Celtic Life Ins. Co. Horizon CS2	A		$250 Major Med.	80% $5,000	Full Medical Transfer Covg	12 months	$1,455.65
Benefit Trust Life Ins. Med*Star Class 7	A		$100 Major Med.	80% $2,500	Full Medical Transfer Covg	6 months	$1,457.40
Ohio National Life Ambassador Std CC 5000	A+		$250 Major Med.	80% $5,000	Full Medical None	6 months	$1,463.24
Time Insurance Company SigMET $250 ($3,000)	A+		$250 Major Med.	80% $3,000	Full Medical Max $2,000	12 months	$1,468.50
Central Life Assurance CLIENT Pln 150(7500)	A+	?	$150 Major Med.	80% $7,500	Full Medical Max $1,000	12 months	$1,472.43
Pacific Mutual Life PM - Prem Trim $5,000	A+	?	$200 Major Med.	70% $5,000	Full Medical Transfer Covg	12 months	$1,476.63
Central Life Assurance CLIENT C/A 100(7500)	A+	?	$100 Major Med.	80% $7,500	Full Medical Max $1,000	12 months	$1,479.91
Crown Life Insurance Co. Crown Life Gem Plan 1	A+		$100 Major Med.	80% $5,000	Full Medical Max $2,000	6 months	$1,489.10
Provident Mutual Life Leader Split $7,500	A+	S	$100 Major Med.	80% $7,500	Full Medical Max $1,000	6 months	$1,492.69

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Central Life Assurance CLIENT C/A 150(2500)	A+	?	$150 Major Med.	80% $2,500	Full Medical Max $1,000	12 months	$1,494.07
Garden State Life Ins. Amer Emp Pl 11	A		$100 Major Med.	80% $2,000	Full Medical Max $3,000	6 months	$1,495.65
Washington National The Leader Plan C	A+		$150 Ind Maj Med	80% $10,000	Full Medical None	6 months	$1,497.68
Central Life Assurance CLIENT Pln 150(5000)	A+	?	$150 Major Med.	80% $5,000	Full Medical Max $1,000	12 months	$1,503.17
Pacific Mutual Life PM Star Care+ Basic	A+	?	$250 Major Med.	80% $2,500	Full Medical Transfer Covg	12 months	$1,505.77
Central Life Assurance CLIENT C/A 100(5000)	A+	?	$100 Major Med.	80% $5,000	Full Medical Max $1,000	12 months	$1,510.74
Central Reserve Life Simplicity+ 1st $	B+		$100 Major Med.	80% $2,000	Full Medical Max $3,000	12 months	$1,520.00
Provident Mutual Life NET Comp $100/250 $5K	A+		$250 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,524.08
Central Life Assurance CLIENT Plan 150(3500)	A+	?	$150 Major Med.	80% $3,500	Full Medical Max $1,000	12 months	$1,533.83
Ohio National Life Ambassador Std CC 2500	A+		$250 Major Med.	80% $2,500	Full Medical None	6 months	$1,534.64
NN Investors Life Ins. Mass Mkt Pre-cert II	A		$250 Major Med.	80% $5,000	Guar Issue Max $2,500	to 07/89	$1,540.72
Washington National The Leader Plan B	A+		$250 Ind Maj Med	80% $5,000	Full Medical None	6 months	$1,544.37
NN Investors/Pac. Fid. Cost Saver Pre-Cert	A		$100 Major Med.	80% $5,000	Master App Max $500	6 months	$1,556.08
NN Investors/Pac. Fid. 5001 Cost Saver	A		$250 Major Med.	80% $5,000	Master App Max $500	6 months	$1,558.33
Central Life Assurance CLIENT Pln 150(2500)	A+	?	$150 Major Med.	80% $2,500	Full Medical Max $1,000	12 months	$1,565.97
Provident Mutual Life NET Comp $100/250 $7.5	A+		$100 Major Med.	80% $7,500	Full Medical Max $1,000	6 months	$1,566.22
Benefit Trust Life Ins. Med*Star Star S1	A		$100 Major Med.	100% $0	Full Medical Max $2,000	6 months	$1,566.40
Central Life Assurance CLIENT C/A 100(2500)	A+	?	$100 Major Med.	80% $2,500	Full Medical Max $1,000	12 months	$1,573.96
Provident Mutual Life Leader Split $5,000	A+	S	$100 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,585.05

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Time Insurance Company SigMET $100 ($5,000)	A+		$100 Major Med.	80% $5,000	Full Medical Max $2,000	12 months	$1,600.50
Celtic Life Ins. Co. Horizon CS2 w/o HCP	A		$250 Major Med.	80% $5,000	Full Medical Transfer Covg	12 months	$1,610.65
Pacific Mutual Life PM - MPT Plan	A+	?	$150 Major Med.	80% $5,000	Full Medical Transfer Covg	12 months	$1,617.42
Washington National The Leader Plan A	A+		$150 Ind Maj Med	80% $5,000	Full Medical None	6 months	$1,617.76
Provident Mutual Life Plan USA MM6 CC	A+		$300 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,647.80
Pacific Mutual Life PM StarCare+ Basic	A+	?	$100 Major Med.	80% $2,500	Full Medical Transfer Covg	12 months	$1,650.01
Time Insurance Company SigMET $100 ($3,000)	A+		$100 Major Med.	80% $3,000	Full Medical Max $2,000	12 months	$1,655.50
Provident Mutual Life NET Comp $100/250 2.5K	A+		$250 Major Med.	80% $2,500	Full Medical Max $1,000	6 months	$1,657.13
Ohio National Life Ambassador Std CC 5000	A+		$100 Major Med.	80% $5,000	Full Medical None	6 months	$1,658.00
Provident Mutual Life NET Comp $100/250 $5K	A+		$100 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,663.27
NN Investors Life Ins. Mass Mkt Pre-cert II	A		$100 Major Med.	80% $5,000	Guar Issue Max $2,500	to 07/89	$1,668.56
Provident Mutual Life $200 CC $4,000 S/L	A+		$200 Major Med.	80% $4,000	Full Medical Max $1,000	6 months	$1,685.80
Celtic Life Ins. Co. Horizon CS1	A		$100 Major Med.	80% $2,000	Full Medical Transfer Covg	12 months	$1,703.65
NN Investors/Pac. Fid. 5001 Cost Saver	A		$100 Major Med.	80% $5,000	Master App Max $500	6 months	$1,710.19
Provident Mutual Life Leader Split $2,500	A+	S	$100 Major Med.	80% $2,500	Full Medical Max $1,000	6 months	$1,723.55
Provident Mutual Life $200 CC $1,500 S/L	A+		$200 Major Med.	80% $1,500	Full Medical Max $1,000	6 months	$1,731.80
Washington National The Leader Plan B	A+		$150 Ind Maj Med	80% $5,000	Full Medical None	6 months	$1,737.84
Ohio National Life Ambassador Std CC 2500	A+		$100 Major Med.	80% $2,500	Full Medical None	6 months	$1,739.15
Crown Life Insurance Co. Crown Life Gem Plan 4	A+		$100 Major Med.	80% $2,000	Full Medical Max $2,000	6 months	$1,767.10

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Provident Mutual Life NET Comp $100/250 2.5K	A+		$100 Major Med.	80% $2,500	Full Medical Max $1,000	6 months	$1,808.86
Provident Mutual Life Basic CC	A+		$100 Major Med.	80% $2,000	Full Medical Max $1,000	6 months	$1,813.80
Provident Mutual Life Plan USA MM5 CC	A+		$125 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,825.80
Provident Mutual Life Plan USA MM6 Comp	A+		$300 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$1,842.80
Provident Mutual Life Plan USA MM3 CC	A+		$250 Major Med.	80% $1,250	Full Medical Max $1,000	6 months	$1,842.80
Provident Mutual Life Full Pay CC	A+		$100 Major Med.	80% $2,000	Full Medical Max $1,000	6 months	$1,875.80
Celtic Life Ins. Co. Horizon CS1 w/o HCP	A		$100 Major Med.	80% $2,000	Full Medical Transfer Covg	12 months	$1,888.65
Provident Mutual Life Plan USA MM1 CC	A+		$125 Major Med.	80% $1,875	Full Medical Max $1,000	6 months	$1,896.80
Provident Mutual Life $200 $4,000 S/L	A+		$200 Major Med.	80% $4,000	Full Medical Max $1,000	6 months	$1,899.80
Ohio National Life Ambassador Adv 5000	A+		$100 Major Med.	80% $5,000	Full Medical None	6 months	$1,914.00
Provident Mutual Life $200 $1,500 S/L	A+		$200 Major Med.	80% $1,500	Full Medical Max $1,000	6 months	$1,949.80
Provident Mutual Life $250 CC	A+		$250 Major Med.	100% $0	Full Medical Max $1,000	6 months	$1,967.80
Ohio National Life Ambassador Adv 2500	A+		$100 Major Med.	80% $2,500	Full Medical None	6 months	$2,007.95
Provident Mutual Life Plan USA MM5 Comp	A+		$125 Major Med.	80% $5,000	Full Medical Max $1,000	6 months	$2,020.80
Provident Mutual Life Plan USA MM3 Comp	A+		$250 Major Med.	80% $1,250	Full Medical Max $1,000	6 months	$2,038.80
Provident Mutual Life Basic	A+		$100 Major Med.	80% $2,000	Full Medical Max $1,000	6 months	$2,039.80
Provideht Mutual Life Plan USA MM1 Comp	A+		$125 Major Med.	80% $1,875	Full Medical Max $1,000	6 months	$2,089.80
Provident Mutual Life Plan USA MM4	A+		$250 Major Med.	100% $0	Full Medical Max $1,000	6 months	$2,089.80
Provident Mutual Life Full Pay	A+		$100 Major Med.	80% $2,000	Full Medical Max $1,000	6 months	$2,115.80

CARRIER & PLAN	BEST Rtng	Foot Note	Deductible & Plan Type	Co-ins Stop Loss	Underwriting and Takeover	Rate Guar	Company Premium
Celtic Life Ins. Co. Horizon FP1	A		$200 Major Med.	100% $0	Full Medical Transfer Covg	12 months	$2,125.65
Provident Mutual Life Plan USA MM2	A+		$125 Major Med.	100% $0	Full Medical Max $1,000	6 months	$2,217.80

Foot - P = Pending rate change
? = Industry - Call H.O.
S = Split deductible
R = Room & board limit
Note - X = Did NOT meet specs

Plan - Major Med = Fee for service, choice of providers
PPO = Preferred Provider Organization
HMO = Health Maintenance Organization
Blue Cross / Shield = prepaid
Type - Swing Plan = Choose PPO/HMO or own provider

Totals above include life insurance, administration fees and optional benefits if requested. Final rates will be determined at time of enrollment.

Listing of Non-Qualifying Trusts

for

SAMPLE CASE COMPANY

Trust name	Reason not quoted
Aetna CMP (1/89)	Deductible/Benefits
AetnaCare	Maternity
American Community	Fewer than MINIMUM Lives
BEST 1 Plus	Maternity
BEST PM	BEST rating
BEST Price Saver	BEST rating
CRL Light	Maternity
Cal/Net Alliance Trust	Not available in that area
Champ III	Industry
Choice One	Maternity
Comb Emp Tr	Deductible/Benefits
EGIS	Pending Rate Change
Guard'n MI	Pending Rate Change
Independence Plan	Maternity
National Group Trust	Pending Rate Change
Opti-Med Plus	Maternity
Times 24 Karat	Maternity
United Chambers	BEST rating

NOTE: Only plans fitting published ELIGIBLE INDUSTRY list have been quoted. Agent is responsible for FINAL INDUSTRY eligibility. No in-force coverage should be terminated until acceptance of the group has been received.

Ben-E-Med Basic DD
for
SAMPLE CASE COMPANY

#	Employee	Cov'g	Life amt	MONTHLY PREMIUM Life	Employee Medical	Employee Options	Dependent Medical	Dependent Options	Total
1	K. GIBSON	M-29-FA	$7,500	1.95	38.70	10.32	102.34	31.82	185.13
2	L. EVANS	F-44-ES	$7,500	3.45	59.34	9.46	79.98	12.04	164.27
3	B. WILLIS	M-39-EC	$7,500	2.33	43.86	10.32	49.02	-1.72	103.81
4	M. JACKSON	M-26-EE	$7,500	1.95	38.70	10.32	0.00	0.00	50.97
5	T. SELEK	M-38-FA	$7,500	2.33	43.86	10.32	112.66	20.64	189.81
6	T. CRUISE	M-24-ES	$7,500	1.95	38.70	10.32	56.76	31.82	139.55
7	W. HOUSTON	F-24-EE	$7,500	1.95	38.70	10.32	0.00	0.00	50.97

Summary: Ben-E-Med Basic DD – $250 deduct

	Plan Requested $250 ded - 70%-$5,000 Averages	#	Totals	Optional Plans $500 70%-$5,000	$1,000 70%-$5,000
Employee life	2.27	7	15.91	15.91	15.91
Employee medical	43.12	7	301.86	270.27	210.60
Employee options	10.20	7	71.38	63.91	49.80
Dependent medical	80.15	5	400.76	358.82	279.60
Dependent options	18.92	5	94.60	84.70	66.00
Administration fee	2.86	7	20.00	20.00	20.00
			=========	=========	=========
TOTAL COMPANY PREMIUM			$904.51	813.61	641.91

FIRST MONTH'S PREMIUM $904.51 (Initial fees included, if any)

**SPECIAL-¦ Rates guaranteed for 6 months
**NOTES---¦ None

OPTIONS:--		Cost of Option -Included Above?--	Total Monthly Premium for Options --Employees	--Dependents	--Group--
	1) Maternity	Yes	71.38	94.60	165.98
	2) Dental	No	76.30	65.30	141.60
	3) Supp. accident	No	10.15	16.45	26.60
	4) Rx Card	No	49.60	61.80	111.40
	5) Vision	n/a	---	---	---
	6) Weekly Income	No	69.50	---	69.50

PRIMARY RATES for age 65+: Call administrator

RATE AREA: 6 LIFE: Minimum STD: $100/week LOADS: Trend: 1.00 Industry: 1.00
Census #: 2 Run #: 47 Rates Date: 04/01/89 Date Prep: 06/27/89 Eff Date: 07/01/89

SUMMARY of BENEFITS: Ben-E-Med Basic DD

Carrier: Pan American Life BEST Rating: A+/VIII Available: 1 to 49 lives

Type of plan		Comp. Major Medical
		-
Deductible:	Out-patient	$250 deductible PLUS
	In-patient	$500 deductible - Pre-certification required
	Max # ded per family	3 per family
	Year end carryover	No
Co-insurance & stop loss		70%/30% to $5,000 stop loss
Out-of-pocket maximum		$1,500 per person plus deductible
Lifetime maximum benefit		$2,000,000
Hospital services		R&C - Pre-certification required
Room & board/Intensive care		Semi-private/3 times semi-private
Surgical		Reasonable and customary
Professional services		Reasonable and customary
Skilled nursing facility (SNF)		Paid at 50% of hospital room and board
Optional --	Maternity	Opt at 3 lives w/3 dependent coverages or min $500 ded
	Nursery expenses	Not covered
	Dental	Optional at 1 life
and/or		$50 ded - $1,000 ann'l max - see wait periods
	Vision	Eye Care Plan included with dental option
Additional	Accident coverage	Optional - 100% of first $300
	Prescription drugs	Rx card opt w/$4 generic & $6 std brand copay
	Weekly income (STD)	1st day accident 8th day sickness for 26 wks.
Benefits --	Life insurance	$7,500 life required
Cost ------	Hospital Util/Review	Required to assure maximum plan benefits
	Outpatient surgery	R&C - Required for certain surgeries
	Pre-admission testing	Paid at 100% - deductible waived
Containment	2nd surgical opinion	Paid at 100% - required for certain surgeries
	Pre-Certification	Required for maximum benefits
	Home health care	Reasonable and customary - limitations apply
Features --	Miscellaneous	Pre-certification required for max benefits
24 hour coverage for owners		Provided if not eligible for WC or can legally opt out
Rate guarantee		Rates guaranteed for 6 months
Chiropractic services		Paid at 50% to $40/visit - $1,000 max/year - w/limits
Miscellaneous		Split Deductible Plan
		-
Mental -----------	Inpatient	Pd @ 50% - max 31 days/year - max $3,000/yr
and	Outpatient	Paid @ 50% of $50/visit - max $1,000/yr
Nervous ----------	Aggregate max	Lifetime maximum of $10,000
Substance abuse --	Inpatient	Alcoholism same as Mental & Nervous benefit
and alcoholism ---	Outpatient	Alcoholism same as Mental & Nervous benefit
Underwriting & medical evidence		Full Medical @ 1
		-
		-
Pre-existing conditions		6 prior - 12 under @6 lives (12-12 1-5 lives)
		-
Takeover & replacement provisions		Transfer of cov'g at 15 lives $1,500 at 6 lives
		$1,000 at 3 lives
		Above takeover assumes full medical underwriting
Credit for prior deductible		Yes

Plan Administrator: National Ins. Svcs. Tampa, FL
Marketing telephone numbers: 714-625-3911 or 800-237-0012

NOTE: Refer to master policy or certificate for exact provisions and plan limitations.

Med*Star * S3/S4
for
SAMPLE CASE COMPANY

#	Employee	Cov'g	Life amt	MONTHLY PREMIUM Life	Employee Medical	Employee Options	Dependent Medical	Dependent Options	Total
1	K. GIBSON	M-29-FA	$10,000	1.90	43.00	0.00	133.00	52.00	229.90
2	L. EVANS	F-44-ES	$10,000	2.20	97.00	10.00	80.00	0.00	189.20
3	B. WILLIS	M-39-EC	$10,000	3.50	58.00	0.00	70.00	0.00	131.50
4	M. JACKSON	M-26-EE	$10,000	1.90	43.00	0.00	0.00	0.00	44.90
5	T. SELEK	M-38-FA	$10,000	2.40	52.00	0.00	150.00	32.00	236.40
6	T. CRUISE	M-24-ES	$10,000	1.90	43.00	0.00	63.00	52.00	159.90
7	W. HOUSTON	F-24-EE	$10,000	1.60	63.00	52.00	0.00	0.00	116.60

Summary: Med*Star * S3/S4 – $250 deduct

	Plan Requested $250 ded - 80%-$5,000 Averages	#	Totals	Optional Plans $150 80%-$5,000	n/a
Employee life	2.20	7	15.40	15.40	
Employee medical	57.00	7	399.00	422.00	n/a
Employee options	8.86	7	62.00	65.00	
Dependent medical	99.20	5	496.00	524.00	n/a
Dependent options	27.20	5	136.00	141.00	
Administration fee	2.86	7	20.00	20.00	n/a
			=========	=========	=========
TOTAL COMPANY PREMIUM			$1,128.40	1,187.40	n/a
FIRST MONTH'S PREMIUM			$1,128.40	(Initial fees included, if any)	

**SPECIAL-¦ Rates guaranteed for 6 months
**NOTES---¦ None

OPTIONS:--		Cost of Option Included Above?	Total Monthly Premium for Options Employees	Dependents	Group
1)	Maternity	Yes	62.00	136.00	198.00
2)	Dental	No	110.46	99.11	209.57
3)	Supp. accident	No	6.50	9.25	15.75
4)	Rx Card	n/a	---	---	---
5)	Vision	n/a	---	---	---
6)	Weekly Income	No	46.70	---	46.20

PRIMARY RATES for age 65+: Call administrator

RATE AREA: 12 LIFE: Minimum STD: $100/week LOADS: Trend: 1.00 Industry: 1.00
Census #: 2 Run #: 47 Rates Date: 09/20/88 Date Prep: 06/27/89 Eff Date: 07/01/89

SUMMARY of BENEFITS: Med*Star Star 3&4

Carrier: Benefit Trust Life Ins. BEST Rating: A /VII Available: 2 to 14 lives

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Type of plan		- Comp. Major Medical -
Deductible:	Out-patient	- $150 or $250 ded. ($500 or $1,000 optional)
	In-patient	- Same as above - Pre-certification required
	Max # ded per family	- 3 per family
	Year end carryover	- Yes
Co-insurance & stop loss		- 80%/20% to $5,000 stop loss
Out-of-pocket maximum		- $1,000 per person plus deductible
Lifetime maximum benefit		- $1,000,000
Hospital services		- R&C - Pre-certification required
Room & board/Intensive care		- Reasonable and customary/Reasonable and customary
Surgical		- R&C - Pre-certification reouired
Professional services		- Reasonable and customary
Skilled nursing facility (SNF)		- Reasonable and customary - 21 days maximum
Optional and/or Additional Benefits	Maternity	- Optional at 2 lives with 2 family coverages
	Nursery expenses	- Not covered
	Dental	- Optional at 2 lives - Plan includes orthodontia
	Vision	- Not covered
	Accident coverage	- Optional - 100% of first $300
	Prescription drugs	- Reasonable and customary
	Weekly income (STD)	- 7th day accident 7th day sickness for 26 wks.
	Life insurance	- $10,000 life required
Cost Containment Features	Hospital Util/Review	- Required to assure maximum plan benefits
	Outpatient surgery	- R&C - Pre-certification required
	Pre-admission testing	- Paid at 100%
	2nd surgical opinion	- Paid at 100% - 3rd opinion also covered
	Pre-Certification	- Required for maximum benefits
	Home health care	- Reasonable and customary - limitations apply
	Miscellaneous	- Pre-certification required for max benefits
24 hour coverage for owners		- Provided if not eligible for WC or can legally opt out
Rate guarantee		- Rates guaranteed for 6 months
Chiropractic services		- Reasonable and customary - limitations apply
Miscellaneous		- Pre-certification required for max benefits -
Mental and Nervous	Inpatient	- Reasonable and customary
	Outpatient	- Paid at 50% to $50 of cov'd chgs & 1 visit/wk
	Aggregate max	- $10,000/year or $30,000 lifetime maximum
Substance abuse and alcoholism	Inpatient	- Same as mental and nervous
	Outpatient	- Same as mental and nervous
Underwriting & medical evidence		- Full Medical @ 2 - -
Pre-existing conditions		- 6 prior - 6 free - 18 under plan -
Takeover & replacement provisions		- Transfer of cov'g at 10 lives $2,000 at 2 lives - Above takeover assumes full medical underwriting -
Credit for prior deductible		- Yes - at 10 lives

Plan Administrator: Star Mktg & Admin. Des Plaines, IL
Marketing telephone numbers: RPO FINANCIAL SERVICES (313) 477-0115

NOTE: Refer to master policy or certificate for exact provisions and plan limitations.

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                              PEP I $5,000

                                  for

                          SAMPLE CASE COMPANY

                                      ¦---------------- MONTHLY PREMIUM -----------------¦
                                      ¦      Employee           ¦    Dependent    ¦        ¦
 #     Employee       Cov'g ¦Life amt ¦ Life ¦Medical ¦Options¦Medical ¦Options¦  Total ¦
--- ---------------¦--------¦---------¦------¦--------¦-------¦--------¦-------¦--------¦
 1  K. GIBSON      ¦M-29-FA¦ $10,000 ¦ 2.20 ¦  51.34 ¦  0.00 ¦ 135.97 ¦ 46.44 ¦ 235.95
 2  L. EVANS       ¦F-44-ES¦ $10,000 ¦ 4.50 ¦  97.87 ¦ 10.49 ¦  96.15 ¦  0.00 ¦ 209.01
 3  B. WILLIS      ¦M-39-EC¦ $10,000 ¦ 3.00 ¦  70.48 ¦  0.00 ¦  79.75 ¦  0.00 ¦ 153.23
 4  M. JACKSON     ¦M-26-EE¦ $10,000 ¦ 2.20 ¦  51.34 ¦  0.00 ¦   0.00 ¦  0.00 ¦  53.54
 5  T. SELEK       ¦M-38-FA¦ $10,000 ¦ 3.00 ¦  70.48 ¦  0.00 ¦ 165.18 ¦ 19.48 ¦ 258.14
 6  T. CRUISE      ¦M-24-ES¦ $10,000 ¦ 2.20 ¦  51.34 ¦  0.00 ¦  75.72 ¦ 46.44 ¦ 175.70
 7  W. HOUSTON     ¦F-24-EE¦ $10,000 ¦ 2.20 ¦  64.18 ¦ 14.98 ¦   0.00 ¦  0.00 ¦  81.36

       Summary:  PEP I $5,000 - $250 deduct

                              ¦------ Plan Requested ------¦------ Optional Plans -----¦
                              ¦  $250 ded - 80%-$5,000     ¦    $100     ¦    $500     ¦
                              ¦ Averages   #     Totals    ¦ 80%-$5,000  ¦ 80%-$5,000  ¦
                              ¦---------- ---  ----------  ¦-------------¦-------------¦
Employee life                      2.76    7       19.30   ¦      19.30  ¦      19.30  ¦
Employee medical                  65.29    7      457.03   ¦     505.99  ¦     370.94  ¦
Employee options                   3.64    7       25.47   ¦      25.47  ¦      22.47  ¦
                                                           ¦             ¦             ¦
Dependent medical                110.55    5      552.77   ¦     610.48  ¦     449.07  ¦
Dependent options                 22.47    5      112.36   ¦     116.85  ¦      95.88  ¦
                                                           ¦             ¦             ¦
   Administration fee              0.00    7        0.00   ¦       0.00  ¦       0.00  ¦
                                                 =========  ¦  =========  ¦  =========  ¦
       TOTAL COMPANY PREMIUM                   $1,166.93   ¦   1,278.09  ¦     957.66  ¦

       FIRST MONTH'S PREMIUM                   $1,166.93  (Initial fees included, if any)

**SPECIAL-¦  Rates guaranteed for 12 months
**NOTES---¦  None

                                 ¦ Cost of Option      ¦  Total Monthly Premium for Options ¦
            ¦--------------------¦-Included Above?--¦--Employees----Dependents----Group--¦
            ¦  1)  Maternity     ¦       Yes          ¦    25.47        112.36      137.83 ¦
            ¦  2)  Dental        ¦       No           ¦    98.00        115.00      213.00 ¦
OPTIONS:--¦  3)  Supp. accident ¦       Yes          ¦     0.00          0.00        0.00 ¦
            ¦  4)  Rx Card       ¦       n/a          ¦     ---           ---         ---  ¦
            ¦  5)  Vision        ¦       n/a          ¦     ---           ---         ---  ¦
            ¦  6)  Weekly Income ¦       No           ¦    61.70           ---       61.70 ¦
            ¦--------------------¦--------------------¦------------------------------------¦
PRIMARY RATES for age 65+: Call administrator

RATE AREA: 6     LIFE: Minimum    STD:  $100/week   LOADS: Trend: 1.0C   Industry: 1.00
Census #: 2      Run #: 47     Rates Date: 02/01/89  Date Prep: 06/27/89  Eff Date: 07/01/89
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SUMMARY of BENEFITS: PEP OptI(250)

Carrier: Amer. Community Mutual   BEST Rating: A /VI   Available: 3 to 9 lives

Type of plan		Comp. Major Medical
Deductible:	Out-patient	$250 deductible ($100 & $500 optional)
	In-patient	Same as above - no split deductible
	Max # ded per family	$500 aggregate per family
	Year end carryover	Yes
Co-insurance & stop loss		80%/20% to $5,000 stop loss
Out-of-pocket maximum		$1,250 per person - $2,500 per family
Lifetime maximum benefit		$1,000,000
Hospital services		Reasonable and customary
Room & board/Intensive care		Semi-private/Reasonable and customary
Surgical		Reasonable and customary
Professional services		Reasonable and customary
Skilled nursing facility (SNF)		Maximum of $75 per day - max 60 days/year
Optional --	Maternity	Optional at 3 lives
	Nursery expenses	Reasonable and customary
	Dental	Optional at 3 lives
and/or		$50 ded - 3 per family - $1,000 annual max
	Vision	
Additional	Accident coverage	100% of first $300
	Prescription drugs	Reasonable and customary
	Weekly income (STD)	1st day accident 8th day sickness for 26 wks.
Benefits --	Life insurance	$10,000 life required
Cost ------	Hospital Util/Review	Not required
	Outpatient surgery	Reasonable and customary
	Pre-admission testing	Reasonable and customary
Containment	2nd surgical opinion	Reasonable and customary
	Pre-Certification	Not required
	Home health care	Reasonable and customary - limitations apply
Features --	Miscellaneous	None
24 hour coverage for owners		Provided if not eligible for WC or can legally opt out
Rate guarantee		Rates guaranteed for 12 months
Chiropractic services		Limited benefit
Miscellaneous		None
Mental -----------	Inpatient	Paid at 50% - lifetime maximum $25,000
and	Outpatient	Pd @ 50% to $35/visit - max 50 visits/year
Nervous ----------	Aggregate max	Lifetime maximum of $25,000
Substance abuse --	Inpatient	Not covered
and alcoholism ---	Outpatient	Not covered
Underwriting & medical evidence		Full Medical @ 3
Pre-existing conditions		Immed coverage if condition is listed on app and not excluded by rider; otherwise 24 months under plan
Takeover & replacement provisions		No takeover benefits
		Above takeover assumes full medical underwriting
Credit for prior deductible		Yes

Plan Administrator: Amer. Community Mutual   Livonia, MI
Marketing telephone numbers: RPO FINANCIAL SERVICES 313-477-0115

NOTE: Refer to master policy or certificate for exact provisions and plan limitations.

COMPARISON of SELECTED PLANS
for
SAMPLE CASE COMPANY

	Ben-E-Med Basic DD	Med*Star * S3/S4	PEP I $5,000
BEST rating	A+/VIII	A /VII	A /VI
Type of Plan	Comp. Major Medical	Comp. Major Medical	Comp. Major Medical
Cut-patient deductible	$250	$250	$250
In-patient deductible	$500 ded./Precert reqd	Same as above-Pre-cert	Same as above
Max # ded/family	3 per family	3 per family	$500 agg/family
Co-insurance/stop loss	70%-$5,000	80%-$5,000	80%-$5,000
Out-of-pocket maximum:			
Per person	$1,500/pers+ ded	$1,000/pers+ ded	$1,250/person
Per family	$4,500/fam + ded	$1,500/pers+ ded	$2,500/family
Lifetime maximum	$2,000,000	$1,000,000	$1,000,000
Hospital services	R&C-Precert Reqd	R&C-Precert reqd	R&C
Room & board	Semi-private	R&C	Semi-private
Intensive care	3 x's S/P	R&C	R&C
Surgical	R&C	R&C-Precert reqd	R&C
Professional services	R&C	R&C	R&C
Maternity	Opt @ 3 lives	Opt @ 2 lives	Opt @ 3 lives
Dental	Opt @ 1 life	Opt @ 2 lives	Opt @ 3 lives
Vision	Eye Care w/Dental Opt.	Not covered	
Accident coverage	Opt-100% of $300	Opt-100% of $300	100% of 1st $300
Prescription drugs	Rx card optional	R&C	R&C
Life insurance	$7,500 req'd	$10,000 req'd	$10,000 req'd
Rate guarantee	6 months	6 months	12 months
Underwriting	Full Medical	Full Medical	Full Medical
Pre-ex conditions	12 prior/12 under	6prior/6free/18under	24 prior
Takeover	Max $1,500	Max $2,000	None

PREMIUM SUMMARY (Totals below include requested options and monthly fees)

	Ben-E-Med Basic DD	Med*Star * S3/S4	PEP I $5,000
Employee life	$15.91	$15.40	$19.30
Employee medical	$301.86	$399.00	$457.03
Employee options	$71.38	$62.00	$25.47
Dependent medical	$400.76	$496.00	$552.77
Dependent options	$94.60	$136.00	$112.36
Administration/other	$20.00	$20.00	$0.00
TOTAL COMPANY PREMIUM	$904.51	$1,128.40	$1,166.93

Executive Dental

Prepared for: SAMPLE CASE COMPANY

	Executive Plan I		Executive Plan II	
	#	Totals	#	Totals
Employee dental	(7)	$127.40	(7)	$108.50
Dependent dental	(5)	$118.20	(5)	$97.70
Admin. fee		$15.00		$15.00
Total Company premium		$260.60		$221.20
Initial fees, if any		$35.00		$35.00

Plan Benefits

	Executive Plan I	Executive Plan II
Deductible	$50/year	$50/year
Maximum/family	3 per family	3 per family
Annual max/person	$2,500	$1,500
Covered charges	Reas. & customary	Reas. & customary
Level #1: Basic		
Cleaning, exams	Paid at 100%	Paid at 80%
Topical Flouride	Paid at 100%	Paid at 80%
X-rays/diagnostic	Pd @ 80% under #2	Paid at 80%
Space maintainers	Pd @ 80% under #2	Paid at 80%
Emergency	Pd @ 80% under #2	Paid at 80%
Special info:	Deductible waived	None
Level #2: Major		
Extractions	Paid at 80%	Paid at 80%
Oral surgery	Paid at 80%	Paid at 80%
Fillings	Paid at 80%	Paid at 80%
Root canal	Pd @ 50% under #3	Pd @ 50% under #3
Gum disease	Pd @ 50% under #3	Pd @ 50% under #3
Waiting period	No wait	No wait
Special info:	None	None
Level #3: Major		
Dentures	Paid at 50%	Paid at 50%
Crowns	Paid at 50%	Paid at 50%
Bridges	Paid at 50%	Paid at 50%
Major fillings	Paid at 50%	Paid at 50%
Waiting period	12 month wait	12 month wait
Special info:	$500/yr. Max.	$500/yr. Max
Orthodontia:	Incl @ 2 pd @ 50%	Not covered
Deductible	$50/person w/above	N/A
Waiting period	12 month wait	N/A
Lifetime maximum	$1,500 per lifetime	N/A
Annual maximum	$250 per year	N/A
Special features:	Ortho included	None
Transfer benefit	@ 10 lives w/apprvl	@ 10 lives w/apprvl
Date of rates:	October 1, 1988	October 1, 1988
Rate guarantee:	6 month initial	6 month initial
Area/premium load	5/ 1.00	5/ 1.00
Underwriter	Congress Life	Congress Life

Prepared by: RPO FINANCIAL SERVICES - PROFESSIONAL AGENTS 06/27/89

June 23, 1989

Senator D. Riegle, Jr
1850 McNamara Federal Blg.
477 Michigan Ave.
Detroit, MI 48228

Dear Mr. Riegle

Thank you for the invitation to the Senate Finance Hearing on Health Care. I would love to attend, but I am scheduled to work that morning in order to help pay for my Medical Insurance. How ironic!

My comments on this issue are:

- Federally funded clinics for all citizens through-out the State. I would gladly pay a slight tax increase for this.
- A discount or refund of insurance premiums for those who have little or no claims during the year.
- Medical Insurance for Part-time employees or being able to buy-in to the program at the discounted rate

I am glad to hear that you are working on this issue. I have confidence in you. Please hurry with a result... Blue Cross has just raised my insurance premiums again. Thank you

Mrs. Dorothy Rofino
4050 Mayfair
Dearborn Hts, MI
48125

written testimony--Senate Finance Subcommittee on Health Hearing
June 28, 1989
by Deborah Adams Roraback

The following is my written testimony and documentation on limitations in insurance coverage to meet the needs of chronically ill and disabled persons in this state.
I'm aware of the needs of persons with disabilities and chronic illnesses & medical conditions from having a chronic illness that is disabling, multiple sclerosis. I'm also representing many other persons in the chronically ill and disabled community at this hearing from

-- the Detroit Center for Independent Living (The CIL assists severely disabled people to live more independently)

-- the Chronic Illness Awareness Coalition of Michigan (the CIAC is made up of 27 member agencies representing various chronic conditions)

I'm also aware of needs through interviewing chronically ill and disabled persons in Michigan for articles I have written for the **Detroit Free Press**. The most recent article I wrote specifically dealt with the problems in the financing of our current health care system, and the gaps and limitations in health insurance coverage. (see attached "Support builds for reforms in financing our health care system", March 19, 1989, Detroit Free Press.)
I have also written on lack of in-home care services coverage and rehabilitation services. (attached)

Bob Griss, a disability policy analyst from Washington, D.C., states "[Persons with disabilities and chronic illnesses] can help us all understand how inadequate is most health insurance for such health related services as rehabilitation, in-home services, and durable medical equipment." I concur with Griss's findings and recommendations, which are contained in his report "Access to Health Care: Measuring the Health Insurance Needs of Persons with Disabilities and Persons With Chronic Illness" Vol. 1, No. 1&2, Sept. 1988.

The aforementioned health related services represent out-of-pocket expenses for persons with chronic illnesses and disabilities, expenses which they cannot afford because many are unemployed or underemployed due to their physical condition.

Other out-of-pocket health related expenses not mentioned above are physical and occupational therapy, mental health therapy, transportation expenses, and respite care. (attached CIAC Supportive Care Subcommittee Minutes document these needs.)

Many barriers exist when persons with disabilities and chronic conditions try to get the care they need. We need a health care financing system in this country that meets health care needs at individual level of need.

(testimony given at Sen. Riegle's health care hearing in Mt. Clemens in July of 1987.) Deborah Adams Roraback

I'm a health services consumer with a chronic illness, multiple sclerosis. M.S. is a chronic, progressive disease of the central nervous system for which there is no effective treatment. I'm here to give testimony on the effects of the lack of support coverage for chronically ill persons. I'm in touch with the needs of the chronically ill through my own firsthand experience and through the following activities -

-interviewing many chronically ill persons for articles I have written for the Free Press (attached) and Conquest newspaper
-being the founder and Program Director of M.S. Peer Support Line, a telephone support network for persons with M.S. and
-serving on various committees and task forces in the community attempting to find ways to meet the support needs of chronically ill and disabled persons.

Most chronic illnesses, like M.S., have intermittent and/or long term catastrophic effects that are not considered, the most seriously devastating being the lack of non-skilled supportive care. My M.S. is in remission now, but in 1984, I suffered a relapse of the disease and was seriously weakened by it, to the point where I needed help to do just about anything-eating, bathing, dressing.

I struggled with the sudden, unpredictable exacerbation of this unpredictable disease with no support except for that my husband could provide when he was not at his full-time job. I also had minimal care provided by a home health aide one hour a day, two days a week. This was covered by my health insurance only because my doctor had prescribed some skilled care (injections of an anti-inflammatory drug ACTH). The general policy of insurers is that if no skilled care is prescribed, the patient needs no home health care assistance. Often, that is not the case. On the days my aide did not come to help me out, I had no choice but to "go without" the care that I needed-the meals and the personal care that I could not give myself. The alternative of hiring private non-skilled care is very costly - in this community at least $60. a day or $8 to $10 an hour. And I hear this same story every day from people who are chronically ill and disabled, people who are constantly struggling to obtain the costly non-skilled care they need - the attendant, the transportation, the respite care their care givers need. These people require supportive home care to hold onto their jobs and their families and to make the quality of their lives the best it can be.

Because insurance coverage does not exist for non-skilled care, the only alternative is costly hospital acute care for a patient who has a chronic condition and cannot care for themselves. During the 1984 exacerbation of my M.S., I spent one month in the hospital to receive intraveneous medication that could just as easily and more comfortably been administered to me at home at a fraction of the cost of acute hospital care. But I had no choice but to go the route of hospital care because acute hospital care is covered, while non-skilled care is not covered.

Financially, the effects of chronic illness is devastating. At the present time, to remain in remission, by doctor recommends that I only work part-time, and continue to get alot of rest. The amount of money I could earn working part-time would not be enough for me to meet my basic living expenses, and I do not qualify for any government assistance the way these programs are set up now. Because of the relapsing - remitting nature of the M.S., I have insufficient work history record (by only 3 months) to qualify for SSDI. And I am also ineligible for the other governmental assistance program (SSI) because I am not what is considered "totally disabled" to qualify for that program. So I, like many other chronically ill persons, am in a Catch-22 type of situation where I fall in between the cracks. All I know is I worked and paid over $12,000. into the Social Security System, and now, when I need that money, I can't get it. The present system simply doesn't meet the needs of persons with chronic illnesses. Related to finances, my out of pocket expenses due to this disease are overwhelming - due to permanent vision problems related to M.S., I don't drive, so to get around, I rely on an inefficient and eroding services of our public transit system and a very costly private transportation service. The total cost for my precribed medication per year is about $600.00. I do not qualify for the state "chore grant" program, which would go a long way towards helping me remain in remission if I could get it. I also do not qualify for any of the state utilities assistance programs or the federal "Meals on Wheels" program. (The latter would have been valuable to me during the 1984 relapse of my M.S.) So, financially speaking, if you don't qualify for state or federal programs, you drain your savings, and go into debt, which has been my experience.

Regarding rehabilitation services in this state, I have been frustrated many times when trying to obtain services from both MRS and the Commission for the Blind. From my experience, the level of service given seems to vary from client to client, because rehab. workers are given so much total control over each individual case. In the present system, each state is given the power to distribute federal rehab. monies and regulate themselves, and really aren't held accountable to anybody.

In sum, the lack of non-skilled, supportive home care coverage, support services and government financial assistance forces persons with chronic illnesses into a more dependent and sometimes destitute level of existence. I could be more independent and productive in society if coverage and support services existed to meet needs.

Some solutions that I see to meet the needs and bridge the gaps are

-health insurance coverage for non-skilled care for chronic conditions. Build into the system enough flexibility so that no matter what the condition is, an individual can get their needs met across the board, whether the condition requires short-term acute, intermittent, or long-term maintainance care. Also, provision of coverage for support services such as transportation, respite care, chore services, etc.

-reform and extend benefits of financial assistance programs such as SSDI and SSI, the Meals on Wheels program, the state utilities assistance program, and chore grant program to meet the needs of the chronically ill population.

-placement of more supportive care services in the community, such as reforming the present public transit system to be more accessible and provide more comprehensive services to meet needs of the chronically ill.

-reform the present Rehabilitative Services system or adopt an alternative plan such as the one proposed by the National Federation of the Blind called "The Free Choice Plan". (Description and fact sheet attached) The plan is a cost-effective approach which would allow clients greater selection of relevant services not limited to those available through assistance by a single agency in each state.

CIAC Supportive Home Care Needs Subcommittee

Minutes

January 22, 1987

In attendance: Andrea Rosner, Debbie Adams Roraback, Sandy Peckens.
Absent: Bonnie Oleszkowitz, Diane Morris.

Debbie went over the purpose of the meeting, which was to discuss and identify needs. She gave the group information on needs given to her by two members of the subcommittee who could not attend the meeting.

ALS Needs: (as reported by Bonnie Oleszkowitz)

- affordable home health care
- transportation
- respite care

MPS Needs: (as reported by Diane Morris)

- home care services
    - including respite care
    - physical therapy
- relief for the family relating to home health care needed badly (caregivers get burned out, need others to take over)

MS needs were discussed, and among them were:

MS Needs:

- supportive home care services
    - homemaker services, chore services
- respite care
- transportation
- physical therapy

Kidney Dialysis Patient's Needs:

- transportation
- non-skilled care (care other than nursing care, such as aides, chore services, homemaker services, etc.)

After identifying the needs, we found that largely they fell in the category of "non-skilled care". The members attending this meeting decided at the next meeting to try to identify what resources are available to meet these needs, and at what cost. It was agreed for committee members to come to the next meeting with directories or any other information they have which would identify resources to meet needs.

It was discussed and decided at this meeting that while this subcommittee identifies resources and costs and does "information sharing" in order to meet needs, it will also try to identify and network with other people and groups in the community who are aware of these same needs. (Debbie gave this subcommittee's identified needs input to Ann Mentz at UCS. She is coordinator of the UCS Chronic Disease Task Force).

CIAC Supportive Home Care Needs Subcommittee

MINUTES

February 23, 1987

In Attendance: Diane Morris, Larry Morris, Bonnie Oleszkowicz, Mary Jane Oleszkowicz, Andrea Rosner, Debbie Adams Roraback.

Absent: Sandy Peckens.

As our previous minutes stated, the purpose of this meeting was to try to identify various home care resources and costs, and also discuss other groups in the community involved and concerned about this issue.

Home Care Costs Diane Morris began the meeting by reporting on what she found out about home care costs after contacting various agencies (like VNA). Briefly, costs are in the area of $60 a day, or $8/hr for home care. *(These figures coincided, in general, with the cost figures Debbie found out regarding home care.) The subcommittee overwhelmingly agreed that these costs are out of reach for most folks with needs arising from chronic illness. *These costs are covered by insurance only if skilled nursing care is prescribed by a physician. Diane also reported on a non-profit home care agency located in Livingston County (which is much like Caregivers in Wayne County).

More Needs Surface and are Identified A new member of the subcommittee, Mary Jane Oleszkowicz, gave input on the needs of leukemia patients (who need support, especially during times of chemotherapy treatments):

Leukemia Needs:

- affordable supportive home care services (chore services, homemaker services)
- transportation
- respite care
- physical therapy
- some way to increase accessibility to services available: Mary Jane voiced to the subcommittee her own experience and frustrations trying to access the current system (i.e. DSS and Social Security), which often leads chronically ill people to quit trying and "give up". Either a more accessible system is needed, or advocates to help chronically ill persons to access the system, or BOTH.

Chronic Asthma Needs: (as reported by Diane Morris)

- generally, asthma needs include all the needs previously identified in these and the previous minutes.

Health Insurance Coverage of Home Care Eroding, Case Mgt. System needed for chronically Ill., GM and Ford Insurance policy option Bonnie Oleszkowicz reported to the group her concern over the erosion of home care coverage, evidenced by the recent action of Blue Cross to drop completely the provision of Occupational Therapy and Physical Therapy for cerebral palsy patients. At this point, it was discussed and examples were given of how in some instances, health insurances companies, only under pressure, will cover and pay for items and services that are otherwise not covered. Bonnie also reported to the group about a new "option" (which may be precedent setting) available to GM and Ford workers regarding health insurance coverage. - The "option" coverage would cover needed home care costs. (Bonnie said she would send a description of the optional coverage to subcommittee members).

Quality of Care At this point, the quality of care of home care was discussed. Larry and Diane Morris told of the lack of quality physical therapy care given to their son, and Bonnie made the point that quality care is, from her experience, care that is responsive to patients needs. The caregiver must be flexible and mesh into the patient's environment and overal care plan.

"Directory" update, P & A Health Insurance Coalition, Jim Neubacher housing group Debbie gave to the group information regarding preparing a "directory" for home care resources (as discussed at a previous meeting). She spoke to Barb Richards at the Area Agency on Aging, who has been a community resource specialist at AAA for 13 years. Her recommendations to our subcommittee were:

- not to undertake the very large task of preparing a directory ourselves, and to instead look into grant funding (through possibly UCS) to prepare such a directory.
- she said the most efficient way to access a large number of services was through area gatekeepers or Information and Referral Agencies - they have all the available current resource information at their fingertips. The problem is, the people who can get I & R service are the 60 and over population, and Barb recommended that our subcommittee look into ways to include the chronically ill community in this group, so that they may also access the I & R services available. In other words, look into ways to get senior services expanded (like I & R, and Meals on Wheels, for instance to include the chronically and terminally ill population.
- Barb recommended one way to do this was to attend area "block grant hearings" where our subcommittee could represent the chronically ill population. Representation is an important factor at these hearings. She said these block grant hearings are going on now and in April, & how area monies on services are spent are decided on at these hearings.

Debbie relayed info. to the group on the newly formed Michigan Protection and Advocacy Health Insurance Coalition. She passed out copies of the P & A Newsletter which contains good background on why this Coalition was organized. Debbie represented this subcommittee at the Coalition's first planning meeting on Feb. 18th Debbie also distributed copies of a column by Jim Neubacher describing a group which she thougt would be useful for the subcommittee to network with to give needs input to. Debbie offered to be the subcommittee rep. at future meetings, & contacted Neubacher for details on the group. He suggested to send him a letter describing our home care needs subcommitte so he could give it to Patrick Babcock, Director of DSS at their March 12 meeting, in order for ou subcommittee group to be included as part of their group. Jim will keep me posted as to their next meeting date, & I will keep the subcommittee posted on these dates, also.

Where do we go from here

It was discussed and agreed to

- contact Sheri Shmedley at UCS about possible "directory" funding
- network with Jim N.'s group and the P & A Health Insurance Coalition group

and • to report back to the CIAC on our activities.

(For those interested, the next P & A Health Insurance Coalition meeting is on Wed., March 25, 1987 from 1-4 p.m. at the Capitol Park Hotel in Lansing)

The date, time, and location of the next Supportive Home Care Needs Subcommittee will be scheduled sometime after the next CIAC meeting in March.

(Enclosed is an article relevant to this subcommittee on Insurance coverage for home care.)

March 1986 Vol. 1 No. 1

CIAC

Chronic Illness Awareness Coalition
of Michigan

More Public Awareness is needed

In May of 1985, Ginger Ladd of the Michigan Lupus Foundation, mentioned to Sylvia Bartlett of the Ileitis and Colitis Foundation, her concern about the need for more public awareness for chronic diseases. At that time, neither one of them thought that in less than one year, their concern would culminate in a forum to be held on March 8, 1986, at Sinai Hospital, addressing the "Emotional Impact of Chronic Illness."

The need to create more awareness for chronic illness is a desperate one. Misconceptions and misinformation are the worst enemies of chronic diseases. It is, therefore, vital to anyone involved with chronic illness--whether as patient, family, or community member--to be correctly informed. This is the purpose of the **CHRONIC ILLNESS AWARENESS COALITION** of Michigan. The CIAC hopes to create awareness of available agencies in Michigan (see back page of this newsletter) which address chronic illness as one of their concerns. The CIAC also hopes to function in an advocacy capacity for persons with chronic illness. It is a non profit organization, strictly concerned with helping persons who are affected by the many aspects of chronic illness.

One out of every three adults in America suffer from a chronic illness or chronic medical condition. Our culture lacks practical information about chronic illness. When we or anyone close to us develops a chronic illness, we are unprepared.

Chronic illnesses are not predictable. As a result, chronically ill persons have been routinely misunderstood and misdiagnosed because of their ever changing symptoms and needs. Even though much attention has been directed toward finding the "cure," little attention has been given to the patient's daily living concerns.

Chronic illness can affect a person at any time during his life. Most of the current information available is directed toward the medical profession, though. Little information is available for the layperson addressing the issues of adjustment, change and personal development following the diagnosis of a chronic disease. This is an area where the CIAC of Michigan can and will help with referral services to agencies where further information may be obtained.

But it is the similarity between chronic illnesses which brought most of the agencies involved together. Problems become smaller when shared by a number of people. Getting started, finding volunteers, sharing information and comparing interests, exchanging expertise, and above all, helping those people afflicted with chronic diseases is the main purpose of the CIAC.

This is only the beginning! We hope that this newsletter, an exchange of information for patients, family, and the community, will be an ongoing activity. Indeed, we can say that with the newly formed CIAC of Michigan, chronically ill patients **are not alone.** Information is available. Contact the appropriate agencies.

For more information on the CIAC, contact the Chairperson, Ginger Ladd, at 775-8330.

Sefra Pitzele, a lupus sufferer, and Robert Phillips, a psychologist, wrote books on chronic illness which you might find helpful reading:

Sefra Pitzele. We are not Alone: Learning to Live with Chronic Illness. Minneapolis: Thompson & Company, Inc., 1985

Robert H. Phillips. Coping with Lupus. Wayne, New Jersey: Avery Publishing Group, 1984

Coalition Reports

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION

Alzheimer's disease is a debilitating and fatal brain disease affecting over 60,000 people in the metropolitan Detroit area. It most commonly afflicts 55 85 year olds.

Alzheimer's begins with occasional memory loss, and usually ends with memory loss and disorientation so profound that most victims do not know their spouse or children, do not recognize themselves in the mirror, and have lost the ability to eat, talk, or walk. These symptoms are not a normal part of the aging process. Scientists do not know the cause or cure for Alzheimer's.

ADRDA-Detroit Area Chapter belongs to the National Association and has 85 100 volunteers. It has six basic program areas: free family support groups throughout Wayne, Oakland, Macomb, and St. Clair Counties; telephone helpline providing 24 hour access to a volunteer counselor; on site counseling offering skilled professional volunteers; promotion of research; community education; and respite care for Alzheimer's caregivers.

AMERICAN LUNG ASSOCIATION OF SOUTHEASTERN MICHIGAN

The ALASM offers programs for the chronically ill patient such as Breather's Clubs, which are monthly educational meetings for patients with asthma, emphysema, chronic bronchitis, and other chronic obstructive pulmonary diseases. They feature guest speakers, films, information on lung disease, and group support all as a means to help patients and their families cope with COPD.

As part of ALASEM's information and education services, free equipment loan service is offered, providing vital breathing machines for economically disadvantaged patients. Camp Sun Deer® is a free summer camp offered annually to asthmatic children.

The one session Cigarette Send-Off® clinics incorporate hypnotherapy and medical information as a means for quitting. The five session Freedom from Smoking® are also offered in the workplace. SMART (Smoking Management, Assessment and Related Techniques) is ALASEM's new consultation service available to corporations interested in developing smoking policies in the workplace.

ARTHRITIS FOUNDATION

Arthritis is an inflammation of the joints, a name for a family of 100 separate diseases, including rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, gout, and lupus. It affects 36 million Americans. It strikes women twice as often as men and is usually chronic. It affects all ages, 1.5 million in Michigan, of which 12,000 are children. It is the leading cause of disability and a leading cause of industrial absenteeism. Arthritis causes people to spend $1 billion each year on quack devices and unproven cures.

The Arthritis Foundation is an agency of the United Way of Michigan. It supports significant research in rheumatic diseases. Patient services and education are available and consist of a variety of educational, social, recreational, and information programs to provide information about arthritis and available referral services.

The Foundation provides services to increase public awareness and dispel misconceptions about arthritis.

EPILEPSY CENTER OF MICHIGAN

Epilepsy is a neurological disorder characterized by seizures.

The Epilepsy Center of Michigan provides specialized medical, psychological, social work, nursing, blood chemistry, and EEG services to over 8,700 patients living in all parts of Michigan. EMC and its Community Resource Persons respond to inquiries by sharing information about all of the medical and social aspects of living with epilepsy.

Research into the basic mechanisms and medical and social consequences of epilepsy is conducted at the Center. Diagnostic evaluations and medical follow ups are provided by epilepsy specialists. Psychiatric, psychological, and social work services are alsoavailable. The Pediatric Seizure Clinic, an outpatient clinic of Children's Hospital of Michigan, is one of the largest treatment facilities of its kind in the United States.

ECM strives for awareness and use of the latest scientific advances in epilepsy diagnosis and treatment.

METROPOLITAN DETROIT COALITION FOR BLOOD PRESSURE CONTROL

The Metropolitan Detroit Coalition for Blood Pressure Control serves area residents by planning, mobilizing, and coordinating community wide efforts to prevent and control high blood pressure. It is comprised of individuals interested in the health of our community from 106 voluntary, private and public health agencies, professional and provider associations, educational institutions, business, industry, and labor groups.

The goal of the Coalition is to prevent and increase control of high blood pressure, and thus reduce disabilities and premature deaths from heart disease, stroke, and kidney failure.

The Coalition's accomplishments include:

- uniform screening, referral and followup methods
- centralization and exchange of information
- innovative and improved hypertension program planning
- educational development for professionals, patients, and consumers

The Coalition's activities include developing medical and public information campaigns, developing mechanisms of support for those with hypertension; organizing and implementing health promotion projects in the community to prevent the onset of high blood pressure.

MICHIGAN PARKINSON FOUNDATION

Parkinson's is a slowly progressive neurological disorder affecting specific areas of the brain. It is characterized by slow movement, involuntary tremor, rigidity, and problems with walking. The cause is unknown; it is not hereditary. There is no known cure. The condition affects people of all ages.

MPF is a non profit corporation. Its primary goal is to help patients and their families cope with Parkinson's. MPF provides a means of early, accurate diagnosis, getting the right combination of medications, obtaining various treatments to assist in managing the condition. Educational workshops include coping with a chronic disease, medication management, effective communication with the treatment team, physical and occupational therapy, and nutrition. Parkinson support groups address patient and family needs. MPF arranges open lectures about Parkinson's encouraging the cooperation of patients and physicians to support clinical research through seminars and manuals, promotes education of all health professionals in order to provide better care to patients with Parkinson's.

METROPOLITAN DETROIT HEALTH EDUCATION COUNCIL

MDHEC is a consortium of over 60 organizations and individuals who are interested in health education. It was established in 1976 by

United Community Services of Metropolitan Detroit, and in 1979 affiliated with the United Health Organization.

MDHEC's goals are to provide a network of communication; strengthen and coordinate health education efforts; encourage new programs; sponsor community conferences; provide health education to the community; raise awareness of the value of self care, self reliance, environment health issues, and knowledge of health resources; and provide a meeting ground for those interested in health education.

MICHIGAN LUPUS FOUNDATION

Systemic lupus erythematosus, or Lupus as it is commonly known, is a chronic inflammatory auto immune disease. It can attack virtually any organ in the body, including the skin, joints, kidneys, brain, lungs, heart, blood and immune system. Lupus can range in severity from mild to disabling and may be life threatening. Lupus, lacking both public and professional awareness, has a significant problem in being diagnosed early. Early diagnosis is important for improved prognosis. The common symptoms of joint pain, low grade fever, weakness, extreme fatigue, a sun-sensitive rash and unusual swelling come and go over a period of time with no apparent cause. Although Lupus can affect both sexes of any age, its primary target is a young woman in her childbearing years. It affects one out of every 400 women and, therefore, is not a rare disease as publicly perceived.

The MLF is a state wide patient oriented volunteer health agency. Its services include programs for patient education, support, individual counseling, research, screening for early diagnosis and professional education through medical symposiums. Although a nearly all volunteer organization, the MLF has serviced over 5,000 persons in the past membership year.

M.P.S. RESEARCH FUNDING CENTER, INC.

Mucopolysaccharidoses (MPS) are a rare group of genetic degenerative storage disorders. They are caused by a lack of a specific enzyme which in normal individuals breaks down complex carbohydrate chains called mucopolysaccharides. These chemical reactions take place with lysosomes, structures found in most cells. As a result of the enzyme deficiency in affected individuals, undegraded mucopolysaccharides are stored in the lysosomes. This abnormal storage accumulates throughout the body causing many debilitating complications which eventually lead to premature death.

Characteristics of MPS are short stature, skeletal deformities, stiff joints, limited mobility, possible mental retardation, deafness, blindness, enlarged liver and spleen, respiratory complications, degeneration of the central nervous system, restricted airways, and heart disease.

The MPS Research Funding Center is a nonprofit organization working towards promoting and funding medical research on detection, control, and cure for MPS and related disorders.

MYASTHENIA GRAVIS ASSOCIATION, INC.

Myasthenia Gravis is a neuromuscular disease which can afflict anyone at any age. Those who suffer with this chronic disorder have nerves that cannot communicate with their muscles and they have all or some of these symptoms: drooping eyelids, blurred vision, double vision, excessive weakness in the arms and legs, slurred speech, nasal voice, difficulty chewing and swallowing, and in severe cases - difficulty breathing. Although there is no cure for MG, with early diagnosis and proper treatment, the disease can be managed and controlled in the majority of cases.

The Myasthenia Gravis Association, a United foundation Torch Drive Agency, provides an extensive support system for patients and their families. Its programs include patient education, counseling and referrals of a social worker, support groups, equipment and assistance for patients with special needs, public awareness campaign, and funding of research into the cause and eventual cure of the disease.

NATIONAL MULTIPLE SCLEROSIS SOCIETY

Multiple Sclerosis is a chronic, progressive disease of the central nervous system. Its symptoms can run from a slight blurring in vision to complete paralysis. The cause is unknown and a cure has not been found.

The Multiple Sclerosis Society - Michigan Chapter, Inc. has eleven branches serving the whole state of Michigan. A non-profit voluntary health agency organized to improve the quality of life for MS persons and their families, it raises funds and develops volunteers to support research into the cause and cure for MS, providing direct services to MS persons and their families, launching public and professional education campaigns.

Specific services include medical out-patient clinics, information and referral, education and recreation groups, Active Coping Techniques program for newly diagnosed, counseling programs for MS persons and spouses, provision of prescribed medical equipment, education programs for family members, professional development programs.

NATIONAL FOUNDATION FOR ILEITIS AND COLITIS

Ileitis and colitis are painful, chronic, digestive diseases afflicting particularly children and adolescents. Symptoms of these diseases are any or all of the following: persistent diarrhea, abdominal cramps, blood passed through rectum, fever and weight loss, joint pains, skin and eye irritation, and delayed growth in children.

The Foundation is a national nonprofit voluntary health organization dedicated to improving the quality of life for persons with Crohn's disease (ileitis) and ulcerative colitis (known collectively as IBD) through patient and physician education programs. It strives to discover the cause and cure of these chronic illnesses by funding medical research projects at medical centers located throughout the United States and several foreign countries.

It is estimated that two million Americans have IBD, of which more than two hundred thousand are children.

The Michigan Chapter is one of over 70 Chapters of the national organization and provides service and support through informational brochures, educational meetings, Chapter newsletters, and a hospital visitor program.

NATIONAL HUNTINGTON'S DISEASE ASSOCIATION

Huntington's Chorea is a hereditary disease of the central nervous system which usually onsets between the ages of 30-50. This slowly progressive nervous condition is marked by involuntary muscular twitching of the limbs or facial muscles.

National Huntington's Disease Assn., the Greater Lansing Area Chapter of NHDA, maintains a Huntington's Disease "Helpline" staffed by a social worker who provides information, referrals, and counseling to HD patients and families, leads support groups for "caregivers," HD offspring who are "at risk" to the disease, and HD patients. The Agency also supplies up-to-date information on HD treatment and research to patients, families, physicians, and health professionals.

NATIONAL KIDNEY FOUNDATION OF MICHIGAN

The goals of the National Kidney Foundation of Michigan are to improve the quality of life of kidney disease patients, to work toward a cure, and to prevent kidney disease through education.

NKFM programs include counseling and referral, drug bank, ID tags, patient advocacy, prescription discount, youth and adult camps, and health planning. Other programs are research grants and fellowships, professional education including medical symposium and professional speakers' bureau, public information including disease prevention, literature, and films, organ donor programs and speakers.

TOURETTE SYNDROME ASSOCIATION, INC.

Tourette Syndrome (TS) is a neurological movement disorder which begins between the ages of 2 and 16 and lasts throughout life. TS is NOT degenerative and people with TS can expect to live a normal life span.

TS is characterized by rapidly repetitive multiple movements called "tics," and involuntary vocalizations. Body tics may include rapid eye blinking, head jerking, facial twitches, or other repetitive movements of the torso or limbs. Vocalizations may include repeated sniffling, throat clearing, coughing, grunting, barking or shrieking. Some people with TS may experience echolalia, palilalia, stuttering, or coprolalia. Symptoms have long been misconstrued as a sign of behavioral abnormality or "nervous habits," which they are not. They are symptoms of a neurological disorder caused by a chemical imbalance in the brain.

The Tourette Syndrom Association, Inc. is an organization composed of individuals with TS, their relatives and friends, and other interested people such as medical and educational professionals. Purpose of the organization is to help undiagnosed patients, to publish and distribute medical and nonmedical information, to schedule meetings to exchange information and learn of new developments in the field from informed, knowledgeable speakers, and to support research into the nature and causes of TS.

news·let·ter (nooz'let'er) n.
A printed periodical report devoted to news for a special interest group.

You are our "special interest." Please mail your "news," comments, and inquiries concerning the CIAC of Michigan to the Editor, c/o 3832 Grayton, Detroit, Michigan 48224.

NATIONAL TUBEROUS SCLEROSIS ASSOCIATION, INC.

Tuberous Sclerosis is a genetic disease affecting many organs. It is most often characterized by two neurological symptoms - epileptic seizures and varying degrees of mental retardation. It is accompanied by benign tumors of the brain and frequently by skin lesions.

Seizures occur in about 95% of individuals with TS. Lesions and tumors are often found in the brain, kidneys, and retina, and can be found in other organs. In the growing child, reddish seed-like bumps may appear in a butterfly pattern across the cheeks and nose. This is called angiofibroma. Another common skin sign are depigmentated areas on the skin and collagenous patches which are slightly elevated, yellowish-brown in color, having the texture of an orange peel.

The Michigan Chapter organizes programs and services such as a pen pal program, exhibits at medical conventions, parent-medical conferences, parent-to-parent contact program, NTSA national registry, medical advisory board, and support groups.

UNITED COMMUNITY SERVICES

United Community Services, through the work of Health Services Division, has been directly involved in the planning of programs and services designed for those with special health needs. UCS believes that access to medical care must remain a high priority with health care providers, legislators, planners, and social service agencies.

Chronic illness is recognized as the leading cause of death among adults. It is also recognized that more children and adults are living with disabling conditions that cause problems with daily functioning. In light of the rapid growth of the older population, and recent technological advances, a growing concern that more individuals will suffer from chronic diseases develops. Efforts must be made to assure availability of comprehensive personalized care. To facilitate these efforts, UCS will implement a planning study to look at the needs of the community, the services available, and the capacity for these services to accommodate special needs. The results of the study will serve as basis to initiate, coordinate, and implement programs to better serve the needs of the community.

UNITED SCLERODERMA FOUNDATION, INC.

Scleroderma is a collagen disease, causing hardening and thickening of the skin, particularly of the hands and fingers. Painful ulcerations generally appear in these areas, as well as the elbows and knees.

Scleroderma is divided into two major forms, localized and systemic. Localized scleroderma involves the skin and subcutaneous tissues and causes cosmetic and mobility problems. Systemic scleroderma affects the organs, namely the esophagus, heart, lungs, intestines, kidneys and/or other skin. The cause is unknown and there is no cure.

The USF offers patients and their families information about scleroderma, contact with other patients, support in coping with scleroderma, and chapters across the nation. Physician referrals are available.

The USF seeks to stimulate and encourage interest in scleroderma throughout the Medical community by regular contacts and research grants.

Coalition Contacts

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, INC.
725 S. Adams, Suite L-6
Birmingham, Michigan 48011
(313) 540-2373
Contact: Diane Wilkins

AMERICAN LUNG ASSOCIATION
28 West Adams
Detroit, Michigan 48226
(313) 961-9096
Contact: Michelle Weglenek

ARTHRITIS FOUNDATION
23400 Michigan Avenue, Suite 605
Dearborn, Michigan 48124
(313) 561-9096
Contact: Maggie Champagne

EPILEPSY CENTER OF MICHIGAN
3800 Woodward - Seventh Floor
Detroit, Michigan 48201
(313) 832-0500
Contact: Thomas Caughlin

METROPOLITAN DETROIT COALITION FOR BLOOD PRESSURE CONTROL
51 West Warren Avenue
Detroit, Michigan 48201
(313)833-0622
Contact: Ann Marie Mentz

METROPOLITAN DETROIT HEALTH EDUCATION COUNCIL
777 Livernois
Ferndale, Michigan 48220
(313) 541-8386
Contact: Karen Gasparach

MICHIGAN LUPUS FOUNDATION
19001 East Eight Mile Road
East Detroit, Michigan 48021
(313) 775-8310
Contact: Ginger Ladd

MICHIGAN PARKINSON FOUNDATION
3990 John R
Detroit, Michigan 48201
(313) 494-8916
Contact: David Nesbitt

M.P.S. (MUCOPOLYSACCHARIDOSES) RESEARCH FUNDING CENTER, INC.
1215 Maxfield Road
Hartland, Michigan 48029
(313) 363-4412
Contact: Diane Morris

MYASTHENIA GRAVIS ASSOCIATION, INC.
6131 West Outer Drive
Detroit, Michigan 48235
(313) 341-5939
Contact: Judy Hofman

NATIONAL FOUNDATION FOR ILEITIS & COLITIS
17000 W. Eight Mile Road-Suite 238
Southfield, Michigan 48075
(313) 424-8656
Contact: Sylvia Bartlett

NATIONAL HUNTINGTON'S DISEASE ASSN.
14688 Turner Road
DeWitt, Michigan 48820
(517) 321-9416
Contact: Sylvia Parker

NATIONAL MULTIPLE SCLEROSIS SOCIETY
21700 Greenfield Road - Suite 409
Oak Park, Michigan 48237-2551
(313) 967-2022
Contact: Betty Motycka

NATIONAL KIDNEY FOUNDATION OF MICHIGAN, INC.
3378 Washtenaw Avenue
Ann Arbor, Michigan 48104
(313) 971-2800
Contact: Sandy Peckens

NATIONAL TUBEROUS SCLEROSIS ASSOCIATION, INC.
23376 Baske
Taylor, Michigan 48180
(313) 291-3781
Contact: Michael A. Stupakis

TOURETTE SYNDROME ASSOCIATION
14450 Elm
Oak Park, Michigan 48237
(313) 398-6621
Contact: Evelyn Tichik

UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT
51 West Warren Avenue
Detroit, Michigan 48201
(313) 833-0622
Contact: Gaylotta Murray

UNITED SCLERODERMA CHAPTER
P.O. Box 766
Pontiac, Michigan 48056
(313) 334-9860
Contact: William Leist

I would like to ensure the continued operation of the CIAC of Michigan with my contribution of $__________.

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Name

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Street

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City Zip

Make checks payable to CIAC-UCS and mail to CIAC of Michigan, c/o 3832 Grayton, Detroit, Michigan 48224.

Coalition Contacts

ALS ALLIANCE OF MICHIGAN
2799 W. Grand Blvd., W1122
Detroit, MI 48202
(313) 876-7046
Contact: Janet Glasberg

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, INC.
17251 W. 12 Mile Rd, Suite 103
Southfield, MI 48076
(313)557-8277
Contact: Diane Wilkins

AMERICAN LUNG ASSOCIATION
28 West Adams
Detroit, MI 48226
(313)961-1697
Contact: Maryellen Mumy

ARTHRITIS FOUNDATION
23999 Northwestern Hwy.
Southfield, MI 48075
(313)350-3030
Contact: Maggie Champagne

CHILDREN'S LEUKEMIA FOUNDATION
19022 W. 10 Mile Rd.
Southfield, MI 48075
(313)353-8222
Contact: Myra Jacobs

EPILEPSY CENTER OF MICHIGAN
3800 Woodward-7th Floor
Detroit, MI 48201
(313)832-0500
Contact: Thomas Caughlin

HEADWAY REHABILITATION FOUNDATION
1 Northland Plaza #1010
Southfield, MI 48075
(313)559-1406
Contact: Rose Elkovich

METROPOLITAN DETROIT COALITION FOR BLOOD PRESSURE CONTROL
51 West Warren Avenue
Detroit, MI 48201
(313)833-0622 x 58
Contact: Ann Marie Mentz

METROPOLITAN DETROIT HEALTH EDUCATION COUNCIL
777 Livernois
Ferndale, MI 48220
(313)541-8386
Contact: Karen Gasparach

MICHIGAN CANCER FOUNDATION
110 E. Warren Ave
Detroit, MI 48201
(313)833-0710 x 247
Contact: Jane Hoey

MICHIGAN LUPUS FOUNDATION
19001 East Eight Mile Road
East Detroit, MI 48021
(313)775-8330
Contact: Ginger Ladd

MICHIGAN PARKINSON FOUNDATION
3990 John R
Detroit, MI 48201
(313)745-2000
Contact: David Nesbitt

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5874 Willow Rd.
West Bloomfield, MI 48033
(313)363-4412
Contact: Diane & Larry Morris

MYASTHENIA GRAVIS ASSOCIATION, INC.
6131 W. Outer Drive
Detroit, MI 48235
(313)341-5939
Contact: Judith Hofmann

NATIONAL FOUNDATION FOR ILEITIS & COLITIS
17000 W. Eight Mile Rd., Suite 238
Southfield, MI 48075
(313)424-8656
Contact: Sylvia Bartlett

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14688 Turner Road
DeWitt, MI 48820
(517)321-9416
Contact: Sylvia Parker

NATIONAL MULTIPLE SCLEROSIS SOCIETY
21700 Greenfield Rd., Suite 409
Oak Park, MI 48237-2551
(313)967-2022
Contact: Betty Motycka

NATIONAL KIDNEY FOUNDATION OF MICHIGAN, INC.
3378 Washtenaw Avenue
Ann Arbor, MI 48104
1-800-482-1455
Contact: Sandy Peckens

NATIONAL TUBEROUS SCLEROSIS ASSOCIATION, INC.
23376 Baske
Taylor, MI 48180
(313)382-5559
Contact: Emily Maddock

TOURETTE SYNDROME ASSOCIATION
14450 Elm
Oak Park, MI 48037
(313)398-6621
Contact: Evelyn Tichnik

UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT
51 West Warren Avenue
Detroit, MI 48201
(313)833-0622
Contact: Gaylotta Murray

UNITED SCLERODERMA FOUNDATION
2271 Telegraph Rd.
Bloomfield Hills, MI 48013
(313)334-9860
Contact: Sara & Bill Leist

I would like to ensure the continued operation of the CIAC of Michigan with my contribution of $__________.

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Name

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Street

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City Zip

Make checks payable to CIAC-UCS and mail to CIAC of Michigan, c/o 3832 Grayton, Detroit, Michigan 48224.

The second forum on **"Emotional Impact of Chronic Illness"** will be held at **Sinai Hospital** on **Saturday, September 27, 1986.**
For more information on the CIAC contact the chairperson, Ginger Ladd, at 775-8330.

Sefra Pitzele, a lupus sufferer, and Robert Phillips, a psychologist, wrote books on chronic illness which you might find helpful reading:

Sefra Pitzele. We are not Alone: Learning to Live with Chronic Illness. Minneapolis: Thompson & Company, Inc., 1985

Robert H. Phillips. Coping with Lupus. Wayne, New Jersey: Avery Publishing Group, 1984

CIAC

CHRONIC ILLNESS AWARENESS COALITION OF MICHIGAN

ALS Alliance-Michigan Chapter Inc.
(313) 676-7046
Alzheimer's Disease and Related Disorders Association
(313) 557-8277
American Lung Association of Southeastern Michigan
(313) 961-1697
Arthritis Foundation, Michigan Chapter
(313) 561-9096
Children's Leukemia Foundation of Michigan
(313) 353-8222
Epilepsy Center of Michigan
(313) 832-0500
Headway Rehabilitation Foundation
(313) 559-1406
Metropolitan Detroit Chapter - Tourette Syndrome
(313) 398-6621
Metropolitan Detroit Coalition for
ood Pressure Control, United Community Services
(313) 833-0622 ext. 58
Michigan Lupus Foundation
(313) 775-8310
Michigan Parkinson Foundation
(313) 745-2000
M.P.S. (Mucopolysaccharidoses) Research Funding Center
(313) 363-4412
Myasthenia Gravis Association
(313) 342-5959
National Foundation for Ileitis and Colitis, Michigan Chapter
(313) 424-8686
National Huntington's Disease Association, Greater Lansing Area Chapter
(517) 321-9416
National Kidney Foundation of Michigan, Inc.
1-800-482-1455
National Multiple Sclerosis Society
(313) 967-3022
tional Tuberous
lerosis Association, Michigan Chapter
(313) [illegible]
United Community Services of Metropolitan Detroit
(313) 833-0622
United Scleroderma Foundation
(313) 334-0860

CIAC Supportive Care Subcommittee

Minutes

July 20, 1987

In attendance: Andrea Rosner, Bonnie Oleszkowitz, Debbie Adams Roraback, Carol Dillon, Carol Freeman.
Absent: Sandy Peckens, Diane Morris, Mary Jane Oleszkowitz.

Two new subcommittee members attended this meeting: Carol Dillon, who, having been employed as an R.N. for several years and is also an ALS patient, is very aware of the needs of persons with chronic illnesses, & Carol Freeman, an R.N. who works at HFH on the Neurology Floor with M.S. and M.G. (Myasthenia Gravis) patients, & she attempts to match them with resources to meet their needs.

More Needs Identified

Carol Freeman gave input on identifying needs:

	M.S. needs	M.G. needs
#1 need -	transportation	transportation
	respite care	respite care

At this point, the desperate need for accessible and comprehensive public transportation was discussed at length by the subcommittee members. Members described their frustrations at using or refering others to use the SEMTA connector service & regular bus services. Mostly they service only within city limits, & it often gets too risky (dangerous) to transfer to another bus line, if transfering is possible at all. It was agreed that there was a real need for a more accessible & comprehensive public transit system in this area, & that without it, the quality of life for chronically ill persons is changed dramatically.

HANDSON update

Debbie gave the group an update on the HANDSON group's efforts.. The group is in the process of incorporating, and has chosen a project director. Debbie also distributed copies of a letter which describes our subcommittee's involvement with the HANDSON group. It was agreed that it's extremely valuable for our subcommittee to continue to support and give needs input to the HANDSON group.

"Home Grocery Shoppers" Resource

Debbie passed around information on a new resource, "Home Grocery Shoppers", a service in the Dearborn, Garden City, Livonia,Redford and Westland areas. This service will do grocery shopping inexpensively (about $5) for handicapper

Supportive care "network"

The need for, value of, and feasibility of a supportive care "network" was discussed. This "network" would simply be a referral-type service, which would hook up handicappers with persons in the community who provide various non-medical care services, such as attendant care, chore services,& transportation. Debbie shared with the group the input and interest of Paul Mueller (Pastoral Ministry for the Handicapped, Archdiocese of Detroit) in starting up such a project, who planned on attending the meeting, but was not able to. It was discussed that for such a referral service, the following would have to be taken into consideration:

- a training of some type, to "screen" caregivers, and to educate them as to the special needs of the persons they care for, -
- someone needed to coordinate the network itself,
- liability concerns.

Debbie distributed a copy of a form letter used by the Downriver Information Center for their own referral network service.
Andrea Rosner offered to contribute her expertise in developing such a project and suggested that those interested(Debbie, Andrea, Paul, & anyone else) set up a future meeting to begin to work on it. Andrea offered to set up that meeting.

Supportive care legislation news

Among the items discussed -

- the local Senate hearings that Senator Riegle is holding on health care issues,
- the National Home Care Association, (has a Michigan chapter, and chapters in 16 other states). This group is very politically active, & has been making progress in amending Medicare to provide for more home care services. (They will be holding a conference in Chicago in November.)
- the public hearing on residential services (housing, etc.) for persons with disabilities held on April 13th in Birmingham -- it was packed.
- Minnesota Home Care Advocacy Program-their"Need for Home care Awareness" conference to be held in November in Minnesota.
- Ann Arbor Mayor's Handicapper Concerns Task Force & Project 2000 Housing Task Force- These groups are working together to come up with a "fact shee on homelessness, which will redefine homelessness to include the disabled and chronically ill. Our CIAC subcommittee is represented on the Project 2000 task force by Debbie.

Brainstorming for Subcommittee focus

At this point, Debbie recorded the issues or topics that had been brought up so far, & more suggestions were added. They were -

* - referral network
  - transportation
* - position statement (re. needs, I.E. transportation, home care, respite care, etc. to be distributed to policy makers.)
* - create awareness regarding needs politically by including state level legislators at meetings & other influentials (like Blue Cross Blue Shield
  - respite care

After discussing which 2 or 3 suggestions we should choose as priorities, it was agreed upon to focus on the *'ed items as a subcommittee.
Those who would work on the referral network item have already been mentioned. Debbie offered to work on a 1st draft of a position statement, & have it done by our next meeting to have the subcommittee look over, revise, & add to. Transportation & respite care would be among the needs highlighted in this statement. Regarding the 3rd item, all members attending this meeting agreed to come up with (identify) names of legislators and other influentials who we could 1) invite to future meetings and 2) distribute our "position statement" to when completed. We all agreed to bring these names to our next meeting. (Note - Don Lozen, Director of the C.I.L. -- Rehab. Institute has sent me a booklet listing state senators & reps. & the committees they're on -- a good place to start.)

The date of the next meeting will be in late September or early October, meeting notices will be sent.

Michael Thomas Ross, M.D., F.A.C.E.P.

June 28, 1989

Senator Donald Riegle
Unitted States Senate
Wahington, DC 20510

Re: Senate Finance Subcommittee written testimony on access to health care for uninsured individuals

Dear Senator Riegle,

Thank you for inviting me to participate in the proceedings of this Senate Finance Subcommittee hearing. Attached to be submitted as testimony is a copy of a letter I wrote you in October of 1987 concerning some of the problems of health care access I have encountered as an emergency physician.

Before offering some of my suggestions for addressing these problems, I'd like to address several technical aspects of access to quality care which concerns all patients regardless of insurance status when emergency care is sought. These concern the impact on an emergency department, its hospital and health care network of unreimbursed care. Unreimbursed care emcompasses uninsured care for which there is no payor, publically or privately insured care for which payment is refused, underpaid or delayed excessively for whatever reasons. The cashflow crisis created by unreimbursed care creates a health delivery crisis which affects everyone.

A simple illustration of this problem is the critical shortage of nurses. No where is this more acute than in the emergency departments and intensive care areas. While there are many lofty theories for the dearth of nurses, inadequate salaries and benefits coupled with terrible working conditions (e.g. overworked, understaffed, undersupplied) explains at least eighty percent of it.

As hospitals struggle to manage the money crisis, cuts in staff and in their salaries and benefits is the first layer of defense followed by cuts in equipment and supplies. Regardless of patients' insurance status, everyone who presents for care will feel the impact of this.

As market forces operate to reward insured and paying patients with better care while averting restrictions imposed by duty to treat statutes and precedents, a multi-tiered health care system evolves rapidly. Free-standing emergency and urgent care centers which serve only paying patients is one form ot this. Express care tracts in hospital based emergency departments are another example. Overt or cleverly concealed VIP programs for admitted patients are yet another. Still, if you are very sick it is difficult to avoid the effects of hospital cutbacks.

I offer the following suggestions as a starting point. The overriding goal must be to assure that all health care is reimbursed adequately. Efficiency and economy will be served by avoiding bureaucracy and assuring the entire system, public and private, is subject to competitive forces.

For uninsured working employees, employers should receive tax incentives to add basic health insurance coverage for the worker and dependents. As well, there should be disincentives for not providing this coverage. State government should be required to offer access to medicaid to small business employers and employees for sliding scale fees.

Similarly, tax incentives and disincentives should be used to urge uninsured self-employed workers or independent contractors to purchase insurance. Here again, low income individuals would be offered access to medicaid for sliding scale fees.

Medicaid needs to continue to serve the indigent who are unemployed. The system needs to be revamped and streamlined and adequately funded. The federal government should set broad standards fo basic coverage and regulation. Medicaid should be required to contract directly with private insurance companies through competitive bidding and get completely out of the business of direct reimbursement. Medicaid's primary function should be to regulate the contracted insurance providers to assure care is paid for appropriately.

Obviously, this can only be a starting point.

Sincerely,

Michael Thomas Ross, M.D.

October 27, 1987

Donald W. Reigle, Jr.
Dirkson Senate Office
Washington, DC 20510

Dear Senator Reigle,

I am an emergency physician working in an urban trauma and emergency center in the southeastern Michigan area. Recently, I cared for a 48 year old man with a broken neck and progressing paralysis sustained in a car accident who our neurosurgical consultant refused to treat. "Transfer him," he said. It was a fog-smothered, rainy night and the nearest, appropriate tertiary referral center was sixty-five miles away.

Two weeks ago I arranged hospital admission for an acutely psychotic, 33 year old, previously healthy man. Circumstances required this gentleman to wait five hours in a hectic, volatile, cramped and crowed emergency department for his hospital bed to be readied. During this wait, this patient was shunned repeatedly by busy nursing staff. So, he left. He returned the next morning requesting help with psychiatric symptoms which tormented him. He waited three hours while I struggled to stabilize six critically ill patients, one of whom needed immediate neurosurgery (the neurosurgeon was busy operating at another hospital). Tired of waiting and suffering, he went home and shot himself in the head. Just as I was getting the other cases under control, a nurse summoned me to pronounce the man dead. Last I had heard, he was still waiting in the gency department.

Last night, a neurologist refused to see a patient with a bizarre presentation of acute neurologic symptoms. Everyday I work, there is at least one and commonly many patients for whom I have great difficulty procuring proper medical care. It is very common for non-life-threatening conditions (eye problems, hand trauma and infections, substance abuse and psychiatric conditions to name a few) and increasingly more common for seriously and critically ill patients.

Right now, the problem most heavily afflicts poor and uninsured patients and those with psychiatric and substance abuse related conditions. The frantic, tumultous health care cost and patient slashing efforts of both public and private third party payers is only just beginning to affect middle and upper class patients. Consider the following.

Emergency and trauma care is increasingly segregated by severity and regionalized to specialized, high tech centers. The law mandates a duty to provide emergency care on demand. To the extent that the hospitals in the regionalized hospital network serve populations which are heavily afflicted with trauma and disease and are uninsured, staffing with physicians, nurses and others must be limited. Now, imagine yourself presenting to a hospital with a deathly heart attack while the emergency physician and his/her sparce team is stretched and stressed maximally with a patient shot in the chest, another with a brain hemmorrhage, two critically injured automobile accident victims and one other heart attack sufferer. Indeed, imagine that the acutely psychotic young man was Edmund Muskie or William McFarland presenting with acute depression and suicidal ideation. How about your wife or mine after a major car accident?

Many government officials view the problems of uninsured or inadequately insured patients and dismiss them as best resolved through the forced charitable donations of care by hospitals and physicians. They allow their uniformed, prejudiced attitudes about health care institutions and physicians to direct their behavior as public leaders and official problem solvers.

Physicians, besieged by public and private insurance plans with skyrocketing regulations and paperwork and diminishing reimbursement, federal, state and local restrictions on their practice, a distressing proliferation of malpractice claims and the attendant duress of securing and paying for malpractice insurance, the challenge of mastering the explosion of medical knowlege and technology and gracefully accepting the rapidly growing distrust, dislike and disrespect of their patients, can no longer afford the luxury of donating their services. Increasingly, they are making themselves unavailable to provide uncompensated care.

Consider further, against this backround, that the federal government as well as private insurers are withdrawing subsidies for medical education at a feverish pace. Hospitals are losing their resident physicians and the demands on attending physicians (those whose training is completed) are consequently intensifying. Already, there's a marked decline in medical school applicants and many physicians are examining other career options. A critical nursing shortage is already exerting its effects.

How will all of this settle out? Must we as Americans settle for a lower standard of health care? Will access to quality care become as limited as in Great Britain or other European nations? If the trend is to less care and limited access, how can we optimize quality and preserve a humane health care system while accepting lower expectations?

Increasingly, I am finding myself forced to lower the quality of care I provide to patients. How well I do my job is my primary source of gratification and this state of affairs is taking that away from me. Think about it. During that midnight shift when I was stuck for ten hours trying to secure proper specialized care for the 48 year old man with the broken neck, I spent an additional thirty minutes making phone calls and another thirty providing hands on care. How did this added demand for my time and the burden of aggravation and frustration it wrought affect the care of the other 35 patients I had to see in that ten hours?

I am very angry by all of this. As an emergency physician, I have three choices: practice shoddy, potentially dangerous patient care, leave medicine, a field I love, and establish a new career, or get into the political arena.

I've decided to take my place among the decision makers and power brokers who have the opportunity to make the right choices for a better way to provide health care to Americans and especially those who have already lost access to basic care. I want to know what you're doing now and what you plan to do to addrees the issues I've reviewed for you here. I'd like to meet you to pursue this further. You can reach me by phone at 313-689-6764.

Thank god you're a senator. What happened to these patients is unlikely to happen to you. It could happen, however, to a family member or to many of your constituents.

Let's do something about it.

Sincerely,

MD

Michael T. Ross, MD

Notes...

June 26, 1987

Dear Senator Riegle,

I received your letter regarding the hearing of the Senate Finance Sub-Committee on Health. I have no specific incident to bring to your attention but I would like to tell you of the high number of people I know who are under-insured or un-insured.

I was born in Royal Oak Michigan. As I was growing up I felt my family was middle class income level. My dad worked for General Motors and our families' health insurance was a benefit. I have eleven siblings ages ranging from 21 yrs to 39 yrs old. Four members of my family have gone yrs uninsured because of high cost of individual policies. Insurance is too costly for individuals who are self employed, or insurance is not a benefit of the company they are employed by. Just recently the uninsured members of my family have purchased policies from American Community Health Insurance. This is a "wellness policy" a well population is all that is covered with riders for any chronic problems. For an individual wellness policy the cost is $80.00 per month. This insurance payment along with the cost of car insurance, car payments, dental care, housing and utilities makes independence of single or self employed individuals unrealistic.

Thank you for your concern,

Renee M. Coy
34641 DAVISON STERLING HTS MI 48310

My name is Mary Ann Ryan and I am a Registered Nurse. I have worked professionally for all but three years since my graduation in 1966. Presently, I am employed as a contingent staff nurse at St. Joseph Mercy Hospital in Pontiac where I have worked for the last 11 years. Over the years I have practiced nursing I have had an opportunity to watch the medical profession increase in knowledge and expertise at a phenonmenal rate. Computer technology alone has brought us to a point that no one could have anticipated when I entered my profession. Today we are saving adults and infants who would have died just five years ago because of advances in our understanding of disease processes and their treatment. Yet in the midst of the progression of modern medicine I am disturbed by what I perceive to be a regression in services available to ordinary people.

When I began nursing medical care was available to everyone. What was not covered by hospital insurance was covered by funds available through community services or city hospitals. I can't recall anyone who was working not having medical insurance. Hospitalization was considered to be a basic right and no one seemed concerned about who paid the bill when the necessity presented itself. I can only recall one patient that I took care of at the Cleveland Clinic being concerned about the total cost of her hospital stay and that was because she had had three kidney transplants and her husband was wealthy enough to not be eligible for the charity funds the institution provided.

Today the story is different. To give you an example of how things have changed I would like to describe the circumstances of two of my friends. Chris has Crohns Disease, a chronic inflammation of the large intestine. This past winter her husband was between jobs when she began to have intestinal bleeding. She didn't go to the hospital because she had no medical coverage and knew she could not pay a hospital bill that would reach thousands of dollars so she stayed home and bled.

Debbie's husband has a heart block. He's a young man who has collapsed several times because of his condition. Unfortunately he is just getting started in his own business and his medical insurance coverage is very limited at this point. So he has gone without a pacemaker because he can't afford to enter a hospital to have one put in.

For the past two years I have served as Chairperson of the Oakland County Parent Advisory Committee for Special Education. This is one of many such federally mandated committees which serves to advise Intermediate School Districts on programs and services for special education children. For the past two years I have had a unique overview of services available to children in all disability areas in not just education but in medicine as well. Although many organizations have provided funding for children with severe impairments, parents are still at the mercy of their insurance companies to provide for hospitalization and related medical services. Last year one of the parents that I work with told me in tears that her husband had changed jobs and his new company had refused to provide medical coverage for their severely mentally impaired son who required extensive medical care. Luckily, the problem was later rectified. The realization remains, however, that with the next job they might not be so lucky. Apparently insurance companies have the right to refuse to cover medically fragile members of a family.

Perhaps the saddest cases that I have dealt with are emotionally impaired children. I have heard stories about the hospitalization of these children and how they have only 45 days in which to get better because that is how long their insurance lasts. After that time, the parents either must pay for hospitalization out of their own pockets or take the children home. Needless to say, the parents I have talked with have taken their children home and tried to deal with sometimes exceedingly difficult behavior.

In the hospital that I work for an honest effort is made to provide medical services to anyone requiring them, but there is not much that can be done when insurance is limited and the patient has to face paying large amounts of money. I am now freqently taking care of elderly men and women who must be sent home with almost equally debilitated spouses. The sole provider of care is the elderly spouse because there is no other financial alterative. It is not unusual to see these patients readmitted frequently simply because their care at home is inadequate. I wonder what has become of a nation that pridesd itself on compassion when I witness such an event.

There is a great need for the government to enter into the area of health insurance. The people whose stories I have told are hard working, conscientious people who do not want handouts but are simply in need of very basic medical care which for financial reasons is not available to them. I am concerned that if the present trends that I am witnessing continue, sophisticated medical care will only be available to the wealthy. Poor and middle class people will be unable to afford the technology of the future. If there is any doubt to the truth of that statement I would like to relate that most of the people I have discussed are of the middle class.

Mary Ann Ryan
391 Waldon Rd
Pontiac, Mi
48057

C.

6-5-89

Dear Sen. Riegle,

I wanted to take a minute and give you an update on how our family is doing. (We are the family you helped to get a waiver some time back.) The difference in our quality of life is amazing. My son is still very ill an spending a lot of time in the hospital but we're grateful for our time with him. Our family have also participated in two documentaries recently. One for Project SPIN (the waiver - Dept. of Mental Health) and the second - Spaulding -

for Children - Permanency Planning (DMH monies & private funding) They were exciting projects.

Through a great community collaborative effort we just finished a ramp for Jonathan. When everyone pitched in the ramp was done in a matter of days. We had a small get-together to celebrate and thought you might enjoy reading the article Pat Andrews wrote about the day.

Hope you have a great summer.

Warm regards,

Kathy Rost

436 Magnolia Blvd
Monroe, MI 48161
June 27, 1989

Honorable Donald W. Riegle, Jr

Received your letter dated June 5, 1989 concerning health insurance program

I feel people in their mid-years ages 50 to 65 yrs. living on low income under $12,000 per year, should be given help with medical expenses if needed. Medicaid was meant to do that but the guide lines are too tight for people trying to stay independent by working low income jobs

I would like to suggest a tax-percentage deduction from all insurance companies in Michigan to be set aside for the benefit of residents in this age group. The residency requirements to be 5 years of permanent residency with job income in Michigan for that period of time. I don't want people moving into the state to live with friends and relatives just for that benefit

I was born, raised, educated and worked in Monroe, MI and would receive help if I need it

Sincerely,
Eunice C. Muller - Mrs J Schroeder

1736 Magnolia Blvd
Monroe, MI 48161
June 27, 1989

Honorable Donald W Riegle, Jr.

We are Seniors and both on Medicare. I have just retired in the last 2 years and my mother is 92 yrs old

We are concerned about the catastrophic insurance. There is a need for it but now we hear that our monies pay for it but it will also be used for AIDS victims and other long term illness. Not just for seniors! Why should seniors pay & all ages benefit?

That is the problem with S.S funds. They (gov't.) has been using those funds for years for, research, immigrants & many other things that do not pertain to senior needs. That is not fair!

If we must pay for this extra insurance then it should be for Seniors Only! That is penalizing the seniors who worked hard to support this program

If we were not living together, mother & daughter, sharing expenses we would have to live in Government subsidized housing — but we like being independent as we were taught in our generation

If it would be a blanket tax (like SS deductions) for everyone and cut down on cost for seniors I might not feel too bitter about it.

Sincerely,

Eunice G. Miller
Odelia Schroeder

June 27, 1989

Testimony:

I was laid-off from a permanent job due to department elimination and not able to find full time employment again

I have been able to find part-time employment with minimum wage, 25 to 30 hours per week Who can live on that? Insurance? Medical Expenses? Dental? Have allergies!

I am living with family who provide food, lodging, transportation to work. I could not survive without them. I feel bad to be so dependent on family that I can't financially meet all my personal needs.

I pray each day for good health or instant death. This is no way to grow old!

Sincerely,
Iris J. Schroeder

June 27, 1989

Testimony

I was stricken with a serious illness at age 59, and was laid-off from a permanent job, due to saniority. I was off work for (4) four months with no income after sick-pay and vacation benefits were used up

My chances of being able to bring back into employment with insurance benefits was slim. I check with medicaid and was told I was too young — 6 months short of being 60 yrs old What to do? A reoccurrence of past illness — I could never pay for medical treatment or medication. Its a scary situation — no insurance and could not afford any I was living with family who provided food & lodging.

I was fortunate to bring back into work — with "God Help & Much Prayer"

Eunice A. Miller

SENIOR AMERICAN COALITION

601 Quincy St. • P.O. Box 4 • Hancock, MI 49930 • Phone: (906) 487-7230

PARTNERS....

CONGREGATIONS of the Northern Great Lakes Synod Evangelical Lutheran Church in America

Copper Country Conference

Atlantic Mine	Our Savior
Baraga	Holy Cross
Calumet	Faith
Chassell	Holy Trinity
Covington	Bethany
Dollar Bay	First
Elo (Pelkie)	Our Saviour
Ewen	First
Hancock	Gloria Dei
Houghton	Good Shepherd
L'Anse	United
Mass City	St. Paul
Mass City	Wainola
Mohawk	Bethany
Nisula	St. Henry
Ontonagon	Siloa
Paynesville	Our Saviour
Pelkie	Faith
Skanee	Zion
South Range	Grace
Trout Lake	Trinity
White Pine	Faith
Winona	First

SUOMI COLLEGE
Hancock, MI

LUTHERAN SOCIAL SERVICES OF WISCONSIN AND UPPER MICHIGAN
Marquette and Calumet, MI

June 27, 1989

Dear Senator Riegle,

I have just been informed of a public meeting you are holding tomorrow the 28th in Southfield.

We are very dissappointed we were not told of this meeting as we certainly would have been there to make our views regarding Health Care for our Seniors in the Upper Peninsula known to you. Since we cannot be there in person due to this late notice I am sending you an update copy of our booklet.

Please keep in touch and know we are available at any time.

Sincerely,

Maureen M Wahmhoff
Advocate

SENIOR AMERICAN COALITION

601 Quincy St. • P.O. Box 4 • Hancock, MI 49930 • Phone (906) 487-7230

'ARTNERS....

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kanee	Zion
South Range	Grace
rout Lake	Trinity
hite Pine	Faith
Winona	First

UOMI COLLEGE
Hancock, MI

LUTHERAN SOCIAL
ERVICES OF WISCONSIN
ND UPPER MICHIGAN
Marquette and Calumet, MI

April 30, 1989

Dear Members of the Certificate of Need Commission,
Dept. of Public Health,
Senators and Legislatures of the Upper Peninsula,

This packet of materials bears witness to a concern we in the Copper Country have had for years. WE DO NOT HAVE ENOUGH NURSING HOME BEDS IN OUR AREA FOR OUR ELDERLY. Our seniors have to be shipped out of their area, at great emotional cost to themselves and their families and friends.

The Long-Term Health Study completed in 1988 by the Department of Health confirms our shartage, Because of a higher proportion of elderly, there is a greater need for nursing home beds in the Upper Peninsula than in the rest of Michigan.

The source of the problem is a state formula which sets quotas for nursing home beds. The quotas for the Upper Peninsula are painfully inadequate. You will be in the process of looking into these issues to make these changes.

We ask for a change in the bed need methodology to allow for more nursing home beds to be added in our area. Because we have been delayed so long in this much-needed reform, we ask that you make the needed changes within six months. We request a firm proposal and a timetable for action by September, 1989.

We stand ready to assist you in any way that we are able. Please call on us. The seniors of the Copper Country and all who are concerned for them thank you.

Sincerely,

Nathan Sager

Nathan Sager
Chairperson, Advocacy Committee
Senior American Coalition

Maureen M. Wahmhoff

Maureen Wahmhoff
Advocate
Senior American Coalition

EXCERPTS FROM THE

SENIOR AMERICAN COALITION

RECORD OF LONG DISTANCE PATIENT PLACEMENT

PATIENT Name: Violet K [illegible] Date of Birth 10-13-19
Home Address: [illegible] Box 64 County: Keweenaw
Sex: Fe Married Widowed ✓ Single
Family/Other Contact Person [illegible]
Address [illegible] Phone 337-
Physician [illegible] Phone
Hospital [illegible] Admission Date 3 2[illegible]-8[illegible]
Discharge/Tranfer Date 4-6-8[illegible]
Level of care at time of discharge:Skilled Basic

Did patient and/or family/respnsible party recieve 3 days written notice of plans to transfer patient? Yes No ✓ Was patient/family/responsible party informed that they could appeal this decision? Yes No
Dis Hospital Social Worker/Discharge Planner offer patient/family assistance with the appeal? Yes No Result of appeal

Nursing Home Powers Adult Care Foster Home
Convalescent Home Home for the Aged
Name of Facility [illegible] Address Powers, MI
Distance from Home 200 miles
(if 2nd transfer) Date Name of Facility
Facility Address Distance from Home
Current Patient location If deceased, date of death 4-7-89 2 days
PLEASE TELL THE STORY OF THIS MOVE IN YOUR OWN WORDS:

Hip surg 3-29-89. One week later she was transferred out of our local hosp. to Powers. Nobody was able to visit her — she was not able to use a walker when transferred 3 days but actually 33 hours later she died. It was late on the 6th when she got to Powers & died early morning on the 7th

Information collected by: [illegible]
Relationship to patient: friend from [illegible] Phone: [illegible]

SENIOR AMERICAN COALITION

RECORD OF LONG DISTANCE PATIENT PLACEMENT

PATIENT Name: George & Catherine Werner Date of Birth Feb, 13/1885--Oct. 31/.
Home Address: Hubbell, Mich County: Houghton, Mich

Sex: Female--Male Married Yes WIdowed ______ Single ______
Family/Other Contact Person Mrs. Gladys Werner Heib

Address 225 N. Iroquois Laurium, Mich. Phone 337 4353
Physician Dr. A.C. Roche deceased Phone ______
Hospital Calumet Public Admission Date ? ?

Discharge/Tranfer Date 1969--1970 ?
Level of care at time of discharge: Skilled ______ Basic Basic

Did patient and/or family/respnsible party recieve 3 days written notice of plans to transfer patient? Yes yes No ______ Was patient/family/responsible party informed that they could appeal this decision? Yes Yes No ______
Dis Hospital Social Worker/Discharge Planner offer patient/family assistance with the appeal? Yes ______ No - Result of appeal ______

Nursing Home Bishop Noa Home Adult Care Foster Home ______
Convalescent Home ______ Home for the Aged Yes
Name of Facility Bishop Noa Home Address Escanaba, Mich
Distance from Home 200 miles
(if 2nd transfer) Date ______ Name of Facility ______
Facility Address ______ Distance from Home ______
Current Patient location ______ If deceased, date of death 1970/1971
PLEASE TELL THE STORY OF THIS MOVE IN YOUR OWN WORDS:

Also had Uncle name of Joseph Sterlin at about age 85 confined to Elders Home in Laurium, Mich he lived in Lake Linden all his life, moved later to Winter Nursing Home in Lanse, Mich where he passed away at age 88. Distance about 52 miles. Great dissappointment to drive this distance because I was widowed at that time. I certainly think we could have a much larger home, with reasonible rates and within our county. One that could accomodate those who would need bed care and also those who just need care and can be up and around. I found that at the Bishop home for them and very reasonable.

Sincerely.

Mrs Gladys Werner Heib

SENIOR AMERICAN COALITION

RECORD OF LONG DISTANCE PATIENT PLACEMENT

PATIENT Name: Mary Ellis Date of Birth 07/08/08
Home Address: 823 Front St. Lake Linden, MI County: Houghton

Sex: Female Married 55 yrs Widowed Single
Family/Other Contact Person Beverly Kolehmainen - daughter

Address 823 Front St, Lake Linden Phone 296-5731
Physician Mikel at time of transfer Phone
Hospital Calumet Public Admission Date March 7, 1988

Discharge/Tranfer Date March 22, 1988
Level of care at time of discharge:Skilled Basic not sure. Private pa

Did patient and/or family/respnsible party recieve 3 days written notice of plans to transfer patient? Yes No X Was patient/family/responsible party informed that they could appeal this decision? Yes No, I don't thin
Dis Hospital Social Worker/Discharge Planner offer patient/family assistance with so the appeal? Yes No Result of appeal

Nursing Home Adult Care Foster Home
Convalescent Home Home for the Aged
Name of Facility Pinecrest Medical Care Address
Distance from Home 160 miles
(if 2nd transfer) Date Name of Facility
Facility Address Distance from Home
Current Patient location If deceased, date of death June 1, 1988
PLEASE TELL THE STORY OF THIS MOVE IN YOUR OWN WORDS:

My mom and dad moved in with me in 1983 so I could take care of them as long as I could. They were admitted ot Our Lady of Mercy Nursing Home in the summer of 1987. Mom was hospitalized in March of 1988. I saw them daily until mom was trasnferred to Pinecrest Medical Care Facility in Powers, 160 miles from home. After almost 56 years of marriage, my dad was not able to see his wife alive after that. She lived two months and ten days after she was admitted to Pinecrest.

After a short time at Pinecrest they said she was considered basic. Because of this she was taken off the list at the Houghton Coun[illegible]cal Care Facility, and there was no chance of getting her back in [illegible]a. Mom had Alzheimers and most basic facilities were not properly equipped to handle her and refused her. She had adverse reacti[illegible] medications (medications - Haldol - caused her death), was pose[illegible] the last few months of her life (for her safety and the safety of [illegible], considered a very difficult patient, but still basic?????

My dad died two months and 20 days after mom died. There is n[illegible] I don't think of them and the heartbreak of their last year of [illegible] lives.

I have written to all the state politicians, even the Governor, state health department.

If there is any way I can help you with anything, please call [illegible]. Work number 482-7382, home 296-5731.

There has been so much money wasted in studies for the need of [illegible] nursing home beds. Anyone knows there is a need. There comes [illegible] when a person is incontinent and needs 24 hour care and a pers[illegible] home can not keep up to this. No one wants to be in a nursing [illegible] it there is a time when it is inevitable.

Information collected by: Bev Kolehmainen
Relationship to patient: daughter Phone: 296 57

SENIOR AMERICAN COALITION

RECORD OF LONG DISTANCE PATIENT PLACEMENT

PATIENT Name: Ronald Berg Date of Birth 6-9-1900
Home Address: RTE 1 CALUMET County:
Sex: M Married X Widowed Single
Family/Other Contact Person MARVIN BERG
Address 200 RED JACKET ST. LAURIUM 49913 Phone 337-1175
Physician DR. ROUWKAMP Phone 337-5540
Hospital CALUMET PUBLIC Admission Date 8-87
Discharge/Tranfer Date 9-87
Level of care at time of discharge: Skilled ✓ Basic
Did patient and/or family/respnsible party recieve 3 days written notice of plans to transfer patient? Yes No ✓ Was patient/family/responsible party informed that they could appeal this decision? Yes No
Dis Hospital Social Worker/Discharge Planner offer patient/family assistance with the appeal? Yes No Result of appeal
Nursing Home LONG TERM CARE Adult Care Foster Home
Convalescent Home Home for the Aged
Name of Facility ONTONAGON HOSPITAL Address ONTONAGON MI.
Distance from Home 74 MILES
(if 2nd transfer) Date Name of Facility
Facility Address Distance from Home
Current Patient location If deceased, date of death 9-13-87
PLEASE TELL THE STORY OF THIS MOVE IN YOUR OWN WORDS:

Information collected by: Marvin Berg
Relationship to patient: Son Phone: 337-1175

SENIOR AMERICAN COALITION

RECORD OF LONG DISTANCE PATIENT PLACEMENT

PATIENT Name: Bertha Raisanen Date of Birth 3-13-14
Home Address: 431 5th St. Calumet, Mi County: Houghton
Sex: F Married____ Widowed____ Single Divorced x
Family/Other Contact Person Martha Pace - sister
Address 1 Park Ave. Calumet, Mi 49913 Phone 337-5714
Physician Dr. [illegible] Phone 337-5540
Hospital Calumet Public Hospital Admission Date 1-12 89
Discharge/Tranfer Date 2-20 89
Level of care at time of discharge:Skilled____ Basic X

Did patient and/or family/respnsible party recieve 3 days written notice of plans to transfer patient? Yes____ No____ Was patient/family/responsible party informed that they could appeal this decision? Yes____ No____
Dis Hospital Social Worker/Discharge Planner offer patient/family assistance with the appeal? Yes____ No____ Result of appeal____

Nursing Home X Adult Care Foster Home____
Convalescent Home____ Home for the Aged____
Name of Facility Superior Shores Nursing Center Address Munising, Mi 49862
Distance from Home 130 miles
(if 2nd transfer) Date____ Name of Facility____
Facility Address____ Distance from Home____
Current Patient location Superior Shores Nursing Center If deceased, date of death____
PLEASE TELL THE STORY OF THIS MOVE IN YOUR OWN WORDS:

Information collected by: Marianne Peterson
Relationship to patient: [illegible] Phone: 337-25[illegible]

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Corrine Terrell
Address 330 Hillcrest Blvd.
Ypsilanti, MI. 48197
Representing :

****

I invite you to attach a prepared statement or to submit your written testimony:

I work as a Public Health Nursing Supervisor in Oakland County. In the past five years our caseloads have increased significantly with clients who are pregnant and have no health insurance. The state has attempted to provide the care through the OBRA Program. While this has helped a larger solution is needed at the federal level. Even with this program women cannot get into care for up to 3-6 wks - which often means they are not seen until late in their second trimester of pregnancy. I wholeheartedly support your efforts to do something about this and will do what I can as well.

Thank you for this hearing.

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Bradley R Shearer

Address 612 Glynn 2E Detroit Mi. 48202

Representing :

****

I invite you to attach a prepared statement or to submit your written testimony:

I have Found iT very DifficulT TO geT insurance Through employer's That I have worked For in The Past 4 yr's. Private Policies are TOO costly I have 2 children, iTs been 3 TO 4yr's Since either of us have seen a Doctor For a Simple check-up.

SHELTER, INC.
AID FOR SPOUSE - ASSAULT VICTIMS

Post Office Box 797 · Alpena, Michigan 49707 · Phone 356-9650

June 27, 1989

Senator Don Riegle, Jr.
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

I am planning to attend the public Senate Finance Committee Health Hearing to be held on Wednesday, June 28th, 1989 in Southfield, Michigan.

The problem of health care for the uninsured is an issue that I am happy to see being addressed. As you are aware, health care costs have sky rocketed to a point where the cost of medical insurance is very cost prohibitive for many individuals and small businesses. At the same time an individual cannot afford to be without it either because one health problem could put an individual in debt for life.

As director of a local private non-profit human service agency, I have another concern. We currently can barely afford employee coverage and do not have dependents health insurance coverage. Our insurance increased 28% over the past year alone. Future increases may very well cost us personnel, which may well be true for many small agencies and small businesses.

Government provided health insurance would perhaps be a better way to go, and levy a business tax based on the labor dollar similiar to worker's comp.
It should not be any more costly than current insurance costs for businesses that provide health insurance.

The main problems that must be addressed for the benefit of all parties concerned are:

1. The containment of law suits to bring down the cost of malpractice insurance costs. We need to examine why we have so many successful law suits being waged and awarded today as opposed to 20 years ago. Should doctors be penalized as strictly for trying to help someone? Perhaps our legal system should bear some of the blame here.

2. we must regulate more strictly the cost of medical care and establish caps or limits on the costs. They must be forced to operate more conservatively. I don't feel that in most cases our medical facilities are being properly managed, and I have yet to see a doctor who is hurting for money. Unless there is a way to contain and bring down the cost of medical care, it would be foolish and unfair to expect the government, individuals, agencies, business or industry to pay the cost... now or in the future.

Thank you for your consideration of my testimony.

Sincerely,

Rasche

Bob Rasche, Executive Director

BR/mt

United Way of Northeast Michigan

July 10, 1989

Dear Senator Riegle,

President Bush just told the Polish people of Gdansk, that America is with them to the tune of $100 millon.

In Southfield, at your Senate Hearing, I heard some very sad stories -- the couple from Imlay City, the Down Syndrome twins from here in Warren, the young woman with Khrons Disease --- these people are Americans who need help.

As an American, I can understand the U.S., trying to overcome Communism by throwing dollars at these countries -- but as an American I cannot understand why some of these dollars can't be used to help people here.

I, too, am an American! Working last year in the Area on Aging Agency program, (without any benefits and at minimum wages, I might add.) I was then placed in a $5.00 an hour job, again no benefits.

As I became unable to work - (swelling legs - numbness in arms & hands) - I applied for Medicaid only - as a temporary means to restore me to employability. I need to work!

Medicaid was denied to me because I'm not old enough. Being 58 years, widowed and no means of support does not qualify me. Imagine my surprise when I learned that I AM discriminated against by AGE. but that Medicaid is available to persons who are not citizens. (See enclosed)

I paid income taxes last year (meager - as were my wages --$6700.) and I'm not entitled to help now when I need it.

I went to Beaumont Hospital - where some tests have been run -- the bills are now coming in and I'm afraid to open them. They are unopened - I can't pay them - and am not well enough to even apply for a job at this time.

My late husband was a World War II veteran, as were 4 of his brothers. My husband was murdered in the streets of Detroit (an undeclared war).

We, the 37 million who are unable to afford or receive medical help, have every right to be bitter, when our tax dollars can support Communist Poland and we give money to the Chinese Communists, so they can slaughter students and leave us to become a growing number of sick and homeless.

Very truly yours,

Mary Jane Sivec

"WITH LIBERTY AND JUSTICE (???) FOR ALL"?

THANK YOU FOR THE INTERPRETER

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In: Name: Brenda J. Smith

Address 3132 Trumbull
Detroit Mi 48216

Representing : Goodwill Industries of Detroit
Coordinator of Deaf Services

****

I invite you to attach a prepared statement or to submit your written testimony:

Disability Deafness:

Must have 24 hour TDD relay system to access any health care.
Call Francine Laurer DOD
1-517-373-0378 TDD

Orientation to Deafness for the Medical Field from Janitors to Administrators
Dr. Lepard SHHBS 1-313-493-6274

Communication access for patients + doctors - cost effectiveness is understanding illness + recovery - Use qualified/certified interpreters. MADHSS Marlaine Ehrenberger
1-517-337-1646

Remember its equally important HOW you say as well as WHAT you say.

Substance Abuse services for deaf people. We need one (1) identified place for S.A. who happen to be deaf toget proper treatment. Talk to MADHSS Marlaine Ehrenberger
1-517-337-1646

Donald W. Riegle, Jr, Senator
1850 McNamara Bldg
477 Michigan
Detroit, MI 48226

Dear Sir:

I am sorry that your announcement arrived two days after your hearing on June 28, 1989. It has taken this amount of time to clarify my own thoughts and conflicts regarding the issue of adequate health for the American people.

In 1974 I was hired at TACOM to direct their Alcohol/Drug Program which eventually became the Employee Assistance Program. Even then the Federal Employees were not covered by insurance for substance abuse treatment. With a lot of effort and resistance we were able to bring the attention of the "leaders" at least to have it included for one year. It was then dropped from any contractual coverage for Federal Employees and to date is inadequate at best.

As a result of our combined efforts the Employee Assistance Director of the Corp of Engineers in your building was moved out of his position into a seat in Personnel eventually having heart surgery and retirement. He had worked actively to have coverage in Michigan and was partially responsible for the three Bills which were eventually passed providing the requirement for substance abuse coverage in Michigan (The fine print read.... Federal Employees not included!)

Because of my efforts I was labeled a " whistle blower", put on a totally non-productive 90 day detail and under much stress and pressure. I then was given the routine "whistle blower" treatment with threats of lose of job, many set -ups, car damage,and constant harassment both on the job and at home. Eventually in 1987 I was removed under an elaborate plan divesting me of all benefits, allowing me to change my health coverage from $1000/year to an individual policy at $ 4000/year, creating paper work in which I could not receive any MESC benefits and in essence being "Black Balled" as far as employment in any organization out side of self employment or contractual employment which I am currently doing. Part of the interesting scenario is that I am diabetic and therefore listed as handicapped under govt regulations and my removal papers were to be given the day I received cataract surgery for $ 5,000.(I was offered none of the procedures of accommodation under the Handicap Laws!) Five months later the second eye had to be operated on with the statement that the "stress I had been under accelerated the need for the second surgery" (Total of $ 10,000 required to retain my vision).

To date I am still not covered by any insurance since the income is not adequate as yet to purchase what is needed. In addition at the time of the removal your office and Senator Carl Levin's office were contacted and both offices chose not to set an appointment or even discuss what was happening. Currently I do not consider myself bitter,I am still a bit angry and have always been willing to fight for what is right but there is more to life than fighting an overgrown system that can not even take care of its own people let alone having procedures that creates groups of people.....i.e. uninsured or even uninsurable.....and then say how can we help you? (I guess there is a bit of bitterness there)

Still let me make a few suggestions:

1. Look carefully at the government health insurance contracting processes. In 1974 the basic contract, written in the 60's was unavailable to anyone even the General at TACOM. Bits and pieces had been negotiated and there were 64 separate contracts. The average employee was not provided adequate information to understand what they were buying. Now I understand the basic contract still is the 60's version and there are well over 400 contracts many being HMO's with the average employee still not adequately informed what he is buying or how to use the process.

(I believe there are still as many as 9 million people affected by this type of coverage).

2. Look carefully at the needs of specialized groups,.....the handicapped, senior citizens, those requiring mental health services, substance abusers, etc and remove the restrictions that have been placed upon the recipients as well as the providers. (working for a private mental health clinic I see some insurance especially for the older populations paying as little as $ 8-22.00/session for mental health services. In some restaurants you can not buy lunch for that amount!!! A large segment of these people do not have adequate transportation even if good competent health care were available.

3. Look carefully at the practices of many insurance companies who create subsidiaries of themselves with a variety of names so that the average consumer who wishes to get out of a certain program does not end up buying a similar one from the same company by another name. In other words help to clear up some of the cash flow into proper locations for adequate health care.

4. Insure that Insurance language is translated for the average John Q. Public so he knows when he purchases the policy what he is buying....what is covered. In the clinic it is not uncommon for the client to be told these services are covered and then when they are billed the clinic is told they are not covered.

Both the client whose therapy becomes interrupted and the client who does not get paid are losers.

5. Get a handle on health care costs...standard scream of the American Public!.Twenty years ago when my daughter was born the hospital plus the doctor cost approximately $ 1000.00. In December when my granddaughter was born the cost was close to $ 15,000 and her's was basically a normal delivery. Catastrophic coverage can not be provided at catastrophic expense!!!

6. Government must continue to set standards but when the VA can not evaluate the credentials of their staff doctor's what proof does the public have that the doctor performing surgery at St. Christopher's Hospital is fully qualified??? And that his bill is accurate and valid. Find ways to insure that hospitals are not double billing or even triple billing (My daughter was injured at school and the Detroit Public School System paid, but my insurance was billed also and they paid and when I was billed and filed a formal complaint against the hospital the whole issue was dropped!! If it happened to me how many others in the United States have the same situation?

7. Find new and innovative ways that new medications can be tested and released by FDA to get to specialized groups and make new procedures available to everyone not selected individuals and/or groups...i.e. transplant program. Recognize that we have new issues such as "Resistance to motorcycle helmet laws is partially from groups hoping to get undamaged livers, hearts etc since most motorcycle deaths are through blows to the head". Resistance to seat belt laws from groups interested in having an increase in auto deaths for transplant purposes (The modern age of technology is upon us)

Thank you for the opportunity to provide some sharing time as well as some suggestions. I realize the complexity of this issue but if it is treated by having an over-all goal and then taking it a piece at a time over the next fifty years there will be some successes and definitely a change in the way health care is provided. A dieter can only lose an ounce at a time, taking the necessary time to reach the ultimate goal. Good Luck!

Sincerely,

David R. Smith
18603 Parkside
Detroit, MI 48221

SOUTHEAST MICHIGAN HOSPITAL COUNCIL

THE SOUTHEAST MICHIGAN HOSPITAL COUNCIL APPRECIATES THE OPPORTUNITY TO PROVIDE TESTIMONY TO THE SENATE FINANCE SUBCOMMITTEE ON HEALTH ON THE ISSUE OF ACCESS TO HEALTH CARE.

HISTORICALLY THE HOSPITAL MISSION HAS INCLUDED PROVIDING HEALTH CARE SERVICES TO MEDICALLY INDIGENT PERSONS IN OUR COMMUNITIES REGARDLESS OF THE INDIVIDUALS' ABILITY TO PAY FOR THEIR CARE. IN 1985, SOUTHEASTERN MICHIGAN HOSPITALS UNCOMPENSATED CARE EXPENSE WAS $140 MILLION. TWO YEARS LATER, IN 1987, THIS HAD INCREASED BY 40% AND IN 1988 IT IS ESTIMATED THAT THE COSTS TO HOSPITALS FOR THE PROVISION OF UNCOMPENSATED CARE FOR SOUTHEAST MICHIGAN RESIDENTS WILL SURPASS THE $200 MILLION LEVEL. TRADITIONALLY, HOSPITALS HAVE BEEN FORCED TO SUBSIDIZE THE COST OF CARE PROVIDED TO THE MEDICALLY INDIGENT BY PASSING ON AT LEAST PART OF THE COST TO PRIVATELY INSURED PATIENTS AND PATIENTS ABLE TO PAY THEIR OWN BILLS THROUGH HIGHER CHARGES FOR SERVICES.

A NUMBER OF THINGS HAVE CHANGED THAT MAKES IT NO LONGER FEASIBLE NOR POSSIBLE FOR HOSPITALS TO CONTINUE THIS PRACTICE. MEDICARE AND OTHER GOVERNMENT PROGRAMS HAVE BEEN FORCED BY BUDGET PRESSURES TO ALTER PAYMENT POLICIES IN A MANNER THAT HAS THE MAJORITY OF HOSPITALS

UNABLE TO RECOUP THEIR COSTS FOR CARING FOR PROGRAM BENEFICIARIES. EMPLOYERS AND INSURERS ARE ALSO INCREASINGLY LESS WILLING TO CONTINUE THE INDIRECT FUNDING OF UNCOMPENSATED CARE. IN MICHIGAN THE HIGH COST OF MEDICAL LIABILITY HAS ALSO CAUSED A SHORTAGE OF SOME TYPES OF MEDICAL SPECIALISTS AND INCREASED THE COST OF PROVIDING MEDICAL SERVICES. WITH EMPLOYMENT SHIFTS FROM MANUFACTURING TO SERVICE SECTOR POSITIONS, IT IS EXPECTED THAT THE POOL OF UNINSURED PERSONS IN SOUTHEASTERN MICHIGAN ESTIMATED TO BE FIVE HUNDRED THOUSAND PERSONS WILL INCREASE IN THE ABSENCE OF A CHANGE IN THE INCENTIVES FACING EMPLOYERS.

RECENT REPORTS ESTIMATED THAT TWO THIRDS OF THE INSURED ARE WORKERS AND THE DEPENDENTS OF WORKERS. MANY OF THESE INDIVIDUALS ARE EMPLOYED BY SMALL BUSINESSES WHERE THERE IS TRADITIONALLY LESS HEALTH INSURANCE COVERAGE. IT IS ALSO WORTH NOTING THAT MANY OF THE UNINSURED EMPLOYED EARN LESS THAN $10,000 PER YEAR AND LIVE IN HOUSEHOLDS WHERE THE INCOME IS LESS THAN 200% OF THE POVERTY INCOME LEVEL (POVERTY LEVEL IS $5,980 FOR A FAMILY OF ONE). THESE PEOPLE ARE GENERALLY NOT ELIGIBLE FOR GOVERNMENT PROGRAMS LIKE MEDICAID.

RESOLVING THE ISSUE OF THE UNINSURED IS CRITICAL. IF THE UNINSURED PROBLEM IS NOT RESOLVED, THE MEDICALLY INDIGENT WILL FIND IT MORE DIFFICULT TO ACCESS ROUTINE MEDICAL SERVICES AND WILL DELAY SEEKING CARE UNTIL AN EMERGENCY CONDITION ARISES. HOSPITALS' UNCOMPENSATED CARE EXPENSE WILL RAISE EVEN HIGHER BECAUSE OF THE DELAY AND THE RESULTING NEED TO TREAT THE PATIENT IN A MORE EXPENSIVE AND HIGHLY TECHNICAL SETTING. UNLESS THE GOVERNMENT CAN FIND WAYS TO PROVIDE ADEQUATE ACCESS TO HEALTH CARE SERVICES FOR THE UNINSURED, THE EXPENSE OF CARING FOR THIS POPULATION WILL FALL ON HOSPITALS WHO CAN LEAST AFFORD TO ABSORB THIS EXPENSE AND ACCESS WILL BECOME MORE DIFFICULT.

PROPOSED SOLUTIONS SHOULD CONSIDER THE FOLLOWING PRINCIPLES:

O THERE MUST BE AGREEMENT THAT EVERYONE SHOULD HAVE ACCESS TO NECESSARY HEALTH SERVICES (A BASIC SET OF BENEFITS). IS THE RIGHT TO ACCESS TO NECESSARY HEALTH SERVICES FOR ALL AMERICANS ONLY A SLOGAN OR DOES SUCH A RIGHT EXIST?

O THERE MUST BE AGREEMENT THAT PROGRAMS THAT PROVIDE COVERAGE TO THE MEDICALLY INDIGENT SHOULD BE ADEQUATELY FINANCED.

O THERE MUST BE AN EQUITABLE DISTRIBUTION OF FINANCING FOR INDIGENT CARE AMONG PUBLIC SECTOR AND PRIVATE SECTOR PARTICIPANTS.

O THERE MUST BE AGREEMENT THAT ALL EMPLOYERS SHOULD PROVIDE REASONABLE HEALTH BENEFITS FOR THEIR EMPLOYEES.

O THERE MUST BE AGREEMENT ON THE EXPANSION OF PUBLIC PROGRAMS FOR THE MEDICALLY INDIGENT WHO OTHERWISE FALL THROUGH THE CRACKS IN CURRENT PUBLIC COVERAGE PROGRAMS.

O THERE MUST BE AGREEMENT THAT RESOURCES MUST BE USED IN THE MOST EFFICIENT MANNER SO AS TO ACHIEVE ADEQUATE ACCESS TO HEALTH CARE SERVICES AND PROVIDE INCENTIVES THAT REWARD EFFICIENCY.

THE SOUTHEAST MICHIGAN HOSPITAL COUNCIL IS PREPARED TO ASSUME AN ADVOCACY ROLE IN CONJUNCTION WITH OTHER ORGANIZATIONS IN ORDER TO DEVELOP HEALTH POLICIES THAT ADDRESS THE NEEDS OF THE UNINSURED.

St Joseph's

HOSPITAL CENTERS

Clinton
15855 Nineteen Mile Road
Mt. Clemens, Michigan 48044
(313) 263-2300

June 23, 1989

The Honorable Donald Riegle
1850 Macnamara Building
477 Michigan Ave.
Detroit, MI 48226

Dear Mr. Riegle:

As a member of the Long Term Care Campaign in Michigan and the manager of an urban hospital discharge planning department, I would like to solicit your assistance in helping me urge the Bi-Partisan Commission on Comprehensive Health Care to schedule one of its hearings in Michigan.

As a member of this Campaign, the Society for Hospital Social Work Directors, Michigan Oncology Social Workers Association and the National Association of Social Workers, I can assure you I have a vested interest in the future health care of our elderly as well as all other age groups. Quality health care should be available to everyone, especially the elderly.

Please help me urge the Commission to come to Michigan so that we can be heard on this important issue.

Sincerely,

Micheline Sommers, MSW, ACSW

Micheline Sommers, MSW, ACSW

MS:eaa

MUSKEGON COUNTY MEDICAL SOCIETY
BOX 445, MUSKEGON, MICHIGAN 49443
TELEPHONE 728-4652

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June 19, 1989

The Honorable Donald W. Riegle, Jr.
United States Senate
Michigan Regional Office
1850 McNamara Federal Bldg.
477 Michigan Avenue
Detroit, MI 48226

Dear Senator:

HEARING TESTIMONY

Having been asked to provide written testimony relative to health access for uninsured individuals, the following opinions and data are submitted:

I would first like to thank Senator Donald Riegle for this invitation and would emphasize that problems in the western part of our state and in the State of Michigan have created a dreadful place for physicians to do business. Access to care, therefore, is an obvious conclusion of that dread. What do I mean by that? First, the uninsured are becoming a greater proportion of folks because of cost of private health insurance or not qualifying for federal or state problems. In Michigan, the number one problem is the malpractice issue and whether our state insurance commissioner believes that an issue doesn't exist is pure ignorance on his part, as he has not taken the time to really research the data. The litigation being filed in this state has driven the cost of doing business to a point where sixty percent (60%) of all residents are leaving the State of Michigan to seek practices elsewhere, thus the cost of their education paid by taxpayers being wasted. Ninety-five percent (95%) of obstetricians graduating or finishing residencies in Michigan are leaving the state because of that excessive cost. Other physicians are taking early retirement because it's just not a healthy atmosphere within which to work. We also have other ones who are just quitting altogether.

I have some data relative to malpractice premiums published in May of this year in the Private Practice Journal. General practitioners with minor surgery in Michigan is $22,642.00, Indiana $4,068.00, Ohio $9,256.00, Illinois $10,761.00. A surgeon's premium in Michigan is $30,187.00, $8,888.00 in Indiana, $15,328.00 in Ohio, $23,126 in Illinois. OB/GYN in Michigan is $51,952.00, Indiana $14,408.00, Ohio $18,570.00 and Illinois $34,255.00. If you look at the average annual malpractice insurance cost per hospital bed in Detroit alone the cost is $9,544.00, rural Michigan is $4,591.00, Florida $5,500.00, Los Angeles $4,658.00, Philadelphia $1,319.00 and New York City, believe it or not, $631.00. I cite these figures as support relative to my claim of the increasing cost of doing business affecting access to care.
Secondly, what impact does this have upon the inter-personal relationships between physicians and their patients? The obvious answer to that is one of an adversarial posture. The threat of suit, seeing every patient, changes the entire way we practice and the art of medicine is removed from that environment. We are losing people willing to take risks in risky situations, because of the threat of litigation, thus, losing access from that point of view. They've also felt that it's their right to file suits if maloccurrence, as opposed to malpractice occurs, and in that event, if society is going to define that as a right, then I think society overall should pay for it, either with compensation funds or in the least, a mandatory arbitration system.

Medical school applications currently are accepting one in two. When I started medical school the applications accepted were one in twenty. I think that tells you something about the attractiveness of the medical profession.

The third point I would like to make is relative to health maintenance organizations, which have evolved as a managed care problem within which the primary care physician is in a catch-22 position. We are mandated to delegate dollars available for care and we do a fairly good job at that. However, we are also mandated to provide to an individual or patient everything updated, regardless of the cost, by our judicial system. Unfortunately, this can't be done. I am sorry but there are only so many dollars and when you remove the judgment and the art from this profession, the cost factors escalate uncontrollably.

The fourth point is PRO, the peer review organizations mandated by HCFA relative to Medicare throughout the country. First, physicians are going to stop taking care of Medicare patients, because of the awesome threat to themselves relative to sanctions, fines, and loss of license, if something shouldn't be absolutely as delegated or felt appropriate by the federal government. I'm sorry, but legislators are not physicians and they are not trained to take care of people from the point of view of disease states that exist or time durations needed to appropriately care for them. I also understand there is a limit to the dollars to provide for Medicare problems, but you will find physicians withdrawing from that sector of care completely, either at the hospital level or their office level if this type of threat continues. I think you should understand that the point system and sanctions imposed at this point in time, pose the greatest threat to delivery care systems in this country. I feel that the uninsured will even have a worse time finding physicians care because of PRO impositions.

What then is the final, ultimate impact? In my opinion, the access to care, not just by uninsured individuals, but by everyone in the State of Michigan will gradually continue decreasing as further state and federal mandates are imposed. Somewhere along the line, common sense has to prevail and at this point in time it has certainly not been forthcoming. The question then becomes, what do you do about existing policies or programs that don't work? Most of us approach them, hopefully, from a common sense posture, which is what you appear to be doing. The malpractice issues that exist have to be changed to attract physicians who are willing to render care, take on new patients, and to do that, it has to be removed from the tort system. It's antiquated, and it doesn't handle the magnitude of the issues with which we deal. Secondly, more physicians have to practice in Michigan. How do we attract them? We attract them by making a healthy environment within which to work and again, at this point in time, the three issues in Michigan, as stated above, are preventing that acquisition. It also seems to me that we have to have a change in what appears to be the federal government's attitude toward the medical profession. Most of us are honest, upright individuals who try to do a good job, but the impressions we get most of the time are that we're money-hungry, mongering people, which isn't true. I think the values of honesty and integrity still permeate our profession and hopefully still have some meaning in our society.

The other ultimate alternative to solving this issue would be a national health insurance program and if instituted, in my opinion, an exodus of probably fifty percent (50%) of existing physicians would be seen. Removing the inter-personal relationship that some of us still cherish with our patients would cause a degradation of that relationship and result in a significant proportion of physicians seeking other types of occupations. There is one basic fact that seems to elude many people when discussing the medical profession. Most of us have the capability, intellectually speaking, of doing many things. We entered this field because of a dedication and a spirit of helping our fellow man. When that is constantly challenged by whatever issue, gradually there becomes a degradation in commitment in even the most staunch individuals.

As far as my own attempts in this community are concerns, we have been licensed for a Medicaid HMO and have shown through experience that when properly administered and financed with controls and sanctions, it can work. It takes a team effort of managerial people to work with us to control the dollars that are available in delivering this care. We are small in number at this point in time, but are continuing efforts every day to enlarge the scope of that care working with hospitals, with providers in other fields relative to the medical profession and in re-educating people through this system that they do, in fact, have access to quality care. There is a responsibility on their part to stop abusing the system, which has become a way of life in our society through what I feel are welfare problems and the attitude of the lottery mentation, which continues to permeate our society. We have also evolved an attitude in our society that says we are no longer responsible for what happens to us. If I place myself in a position of jeopardy, it's somebody else's fault if something happens to me. We also have to work on changing that basic falseness within our society's fiber.

Enclosed are some data compiled in Muskegon, Michigan, and some by the Michigan State Medical Society. I would enjoy having a personal encounter with you at any time to discuss any or all of these issues.

Sincerely yours,

W. Richard Harris MD

W. Richard Harris, M.D., President
Muskegon County Medical Society

Family Health Resources, P.C.
Hackley Professional Center

In 1988 the Muskegon County Medical Society commissioned a survey of medical care for the indigent. The survey gathered information in many ways, but primarily was obtained from:

1. A physician questionnaire regarding physician practices concerning the indigent.

2. Questionnaire for Medicaid patients seeking medical services at the Muskegon County Health Department concerning their need for a family doctor.

3. Analysis of Emergency Room patient population by Medicaid and non indigent patients.

A copy of the survey, Care of the Indigent, a report to the Muskegon County Medical Society, is attached.

From this report some conclusions can be drawn:

1. Medicaid enrollment in Muskegon County totaled $18,500, 13% of the county population. Growth in Medicaid recipients has been at the rate of 6% per year. To fill the larger need at this growth rate, the county would need to add the full-time equivalence of one additional physician each year.

2. For the most part patients requiring referral medical treatment have been able to obtain physicians. The glaring exception has been in obstetrics/gynecology.

3. All data indicates there is an inadequate supply of family care physicians in the county.

4. Emergency Room data indicates that Medicaid patients, 13% of the county's population are responsible for 38% of the encounters in Hackley Emergency Room.

The assumption that indigent patients abuse the Emergency Room facilities is undercut by the data. This indicates that indigent patients use the Emergency Room in the same pattern as non indigent patients.

There is no doubt that there is a need for family practice and OB/GYN physicians in the county. Although this need has not reached epidemic proportions, it is steadily growing as the number of physicians accepting Medicaid patients remains constant and the number of Medicaid patients grows.

Obtaining more family practice or OB/GYN physicians in the county for Medicaid patients is unlikely unless funds are provided to make income for indigent care at least come close to the fees paid at regular charges.

If Medicaid budgets are not allowed to grow realistically, the only alternatives at this point seem to be:

1. More experimentation with managed care systems.

2. Coercive control over physicians requiring participation in caring for the indigent.

Prepared by Family Health Resources, P.C.
June 19, 1989

W. Richard [illegible]

CARE OF THE INDIGENT

A
REPORT TO THE MUSKEGON COUNTY MEDICAL SOCIETY

PREPARED BY:

FAMILY HEALTH RESOURCES, P.C.

The question posed by the Muskegon County Medical Society is:

Does Muskegon need to establish a clinic to provide medical service for the indigent and the doctorless?

There is a simple way to get the answer. Interview each of the more than 20,000 Medicaid recipients in Muskegon County and determine if their needs for medical services are being filled.

Unfortunately, the costs of such a census are beyond our means. But there is some data compiled; there is some data that we can obtain and compile.

The data we need is that required to fill both sides of a classic economic equation -- supply vs. demand.

We seek information that measures or describes the supply of medical service available. We also seek information that indicates demand for medical service, especially unfilled demand.

Some of the information we have obtained is statistical, other anecdotal. By putting it together we hope to get a pattern of evidence from which reasonable minds can deduce reasonable answers.

Let us examine the first half of the equation ---

Our primary information concerning the supply of physicians' services available was obtained from the physicians and their staffs. A questionnaire (Figure 1) was sent to those members of the Muskegon County Medical Society providing treatment for patients. Of 151 questionnaires sent out, 97 were returned. Physicians were asked to describe themselves as primary care physicians or as referral physicians. Thirty-six labeled themselves as primary care physicians and 61 as referral physicians.

Figure 2 tabulates the answers of primary care physicians and referral physicians.

To validate physician responses we telephoned the offices of 52 primary care physicians. The caller, posing as someone who had just moved to Muskegon, asked if the physician would take new Medicaid patients. The results are shown in Figure 3.

In addition to the above evidence, other indications of the availability of physician services were obtained in discussions or reports from various health care professionals. These include:

1. The Muskegon County Health Department maintains a list of physicians available for new patients. Their list, revised to February 1988, indicated that only two M.D.s, who were family practitioners, were taking new Medicaid patients. Both of these physicians were associated with the Koinonia Medical Center.

2. Indications of the availability of physicians' services are the variations in Medicaid payments from year to year. Decreases are caused by physicians who are either no longer practicing in Muskegon County or who are dropping Medicaid patients.

In 1986, eight primary physicians ceased taking Medicaid patients or moved out, resulting in a drop of $162,905 from 1985 Medicaid services paid out to those physicians.

3. One of the factors that could impact availability of physicians' services is the stated intent of Dr. Williams to retire and the future of Koinonia Medical Center. If arrangements for additional supply are not made, somewhere between 2000 and 4000 patients will no longer have a primary care physician.

4. It should be made clear that the opening of the Comprehensive Health Services HMO will not increase M.D. medical service available, since the participating M.D.s are only enrolling their own patients.

FIGURE 1

MEDICAID PATIENT ACCEPTANCE QUESTIONAIRE

	YES	NO
Do you accept as Medicaid patients those that have been your patients prior to going on Medicaid?		
Do you accept as Medicaid patients those that have not been your patients prior to going on Medicaid and applying directly to you?		
Do you accept as Medicaid patients all referrals from M.D.s?		
Do you accept as Medicaid patients some referrals from M.D.s?		
Do you refuse acceptance of all Medicaid patients?		
Would you classify yourself as a primary care or referral physician?	Primary Care	Referral

FIGURE 2

PRIMARY CARE AND REFERRAL PHYSICIAN RESPONSES TO QUESTIONNAIRE CONCERNING MEDICAID PATIENT ACCEPTANCE

	Primary Care Physicians	Referral Physicians
Number of physicians responding.	76	61
Number of physicians accepting new Medicaid patients.	5	49
Number of physicians accepting some selected new Medicaid patients.	5	-
Number of physicians not accepting any new Medicaid patients.	26	1
Number of physicians accepting as Medicaid patients those that have been their patients prior to going on Medicaid.	35	61
Number of physicians accepting all Medicaid payment referrals.	-	50
Number of physicians accepting some Medicaid payment referrals.	-	10

FIGURE 3

TELEPHONE CALL TO PRIMARY CARE PHYSICIANS SEEKING A FAMILY PHYSICIAN FOR MEDICAID RECIPIENTS JULY 15, 1988

Specialty	Total Called	Accepting New Medicaid Patients
Family Practice	21	0
Internal Medicine	17	2
Pediatrics	4	0
OB/GYN	7	1
TOTALS	49	3

The Muskegon County Health Department during the week of July 18-22, 1988, asked all those receiving health services to fill out a questionnaire concerning their need for a family doctor. (See Figure 4)

Figure 5 tabulates the questionnaire.

Figure 6 contrasts the numbers of Medicaid and non-Medicaid patients without family doctors.

Figure 8 lists perceived reasons for not having a family doctor.

Figure 9 lists other sources of medical care.

Figure 10 counts emergency room encounters.

Medicaid enrollment in Muskegon County is 20,800. Approximately 13% of the county's population are Medicaid recipients.

In 1986 Medicaid recipients totaled 18,500. Growth in two years has been at the average amount of 1,150 patients per year or at a compounded growth rate of 6%.

As supply of services has been perceived as restrictive, other health care organizations have mobilized in an effort to provide physicians for doctorless people.

The office of the Muskegon County Medical Society provides a referral service for those seeking physicians. No quantitative records have been kept, but an interview with Barbara Hansen, executive secretary reveals:

--From two to ten phone calls are received daily from people seeking physicians.

--The majority of these are for primary physicians.

-- Some internists will take new patients.

-- Occasionally a few new family practice physicians will take new patients.

-- At this time, no family practice physicians are taking new Medicaid patients.

-- She keeps no list of available physicians, "It's so few, I keep it in my head."

Norton Family Practice counted the calls received from Medicaid patients hunting for a family doctor. For the last week in May it was 9; for the first week of June it was 11.

The Women's Health Center of Hackley has also worked to find physicians for patients. In the past 14 months it has located referral services for 38 obstetrical cases and for an additional 60 Medicaid cases requiring general care.

FIGURE 4

MEDICAID RECIPIENT QUESTIONNAIRE

1. Do you have a family doctor?

   No Yes If YES, who

2. If you have no family doctor, where do you get care for yourself or your children? (Check those that apply to you)

   A. Hospital Emergency Room

   B. Med Stops

   C. Local Health Department

   D. Other (Please list)

3. If you use the Emergency Room for care, how many times have you or your child been there in the last six months?

4. If you do not have a family doctor, which of the following reasons best describes your situation? (Check those that apply to you)

   A. I'm new in town and haven't located a doctor yet.

   B. There are only a handful of doctors who will take Medicaid patients and I do not care to use this limited selection.

   C. I do not feel it is necessary to have a family doctor.

   D. I have called many doctors and none are taking new Medicaid patients.

5. If you were able to select a family doctor of your choice, would you use him/her on a regular basis?

   No Yes

   A. For illness only?

   B. For yearly physicals?

   C. For both well child and illness care?

NOTE: This questionnaire was filled out by non-Medicaid recipients also.

FIGURE 5

PHYSICIAN AVAILABILITY SURVEY
MUSKEGON COUNTY HEALTH DEPARTMENT
JULY 18-22
TABULATION

Number of patients receiving services.	851
Number of families completing questionnaire.	429
Number of families without family physician. (Represents 310 family members.)	137
Number of families with a family physician. (Represents 974 family members)	292
Percentage of families without family doctors.	32%
Percentage of individual patients without family doctors.	24%

FIGURE 6

FAMILIES WITHOUT FAMILY DOCTORS

	Number	Percentage
Families with Medicaid.	69	51%
Families without Medicaid.	66	49%
TOTAL	135	

FIGURE 8

REASONS FOR FAMILIES NOT HAVING A FIMILY DOCTOR

	With Medicaid	Without Medicaid
New in town and have not located a family doctor.	6	9
Do not feel in necessary to have a family doctor.	4	13
Doctors I have called are not taking new patients.	41	17
Do not want to use the doctor/clinic that is available.	10	2
Cannot pay for doctor.	-	4

FIGURE 9

SOURCES OF CARE
FOR THOSE FAMILIES
WITHOUT A FAMILY DOCTOR

	With Medicaid	Without Medicaid
Emergency Rooms	18	14
Med Stops	23	18
Local Health Department	31	29

FIGURE 10

EMERGENCY ROOM ENCOUNTERS
FOR THE PAST SIX MONTHS

	With Medicaid	Without Medicaid
Patients that have family doctors.	89	26
Patients that have no family doctors.	49	13

EMERGENCY ROOMS

Conventional wisdom has held that indigent patients, for whatever reason, are overusers -- often abusers -- of emergency room and med-center services.

We examined one med center's total cash receipts for one month and the total cash received from Medicaid payments. Medicaid payments totaled 8% of total payments received for medical services. However, Medicaid payments are about 40% under fee for service charges. Thus, the 8% received adjusted to the actual charge would be approximately 13%.

Since the Medicaid population of the county is 13% of the total population, this fragment of information indicates that Medicaid patients do not unduly overutilize med centers. However, without measuring further, we cannot assume any significant conclusions from this one piece of data.

However, we did obtain significant data concerning use of hospital emergency rooms.

Specifically we reviewed the Hackley Hospital Emergency Room records for a twelve month period starting May 1987 and running to April 1988.

Figures 12 - 15 are the result.

Figure 12 compares emergency room use for all three hospitals for 1986-1987 and 1987-1988.

Figure 13 compares Hackley Emergency Room use by the non-indigent and the indigent.

Figure 14 compares the amount of treatment for minor medical causes of indigent and non-indigent patients.

Figure 15 compares the ratio of minor treatment patient encounters for indigent and non-indigent patients.

Records of the Mercy Emergency Room also record the proportion of Medicaid out patient visits that are classified as minor care.

For the past 6 quarters minor care encounters for Medicaid were respectively:
12% 15% 11% 11% 11% 7%
of total Medicaid encounters.

A study of the medical needs of the indigent and the doctorless must examine utilization by panel patients.

Panel patients are those that need further care after ER treatment and do not have a physician. They are referred to a panel of staff physicians who provide their services on a rotational basis.

Figure 16 compares the total number of Hackley panel patients and the total number of indigent panel patients.

Figure 17 projects by month the percentage of panel patients that are indigent.

FIGURE 12

EMERGENCY ROOM USE-ALL HOSPITALS
12 MONTHS 86-87 AND 87-88

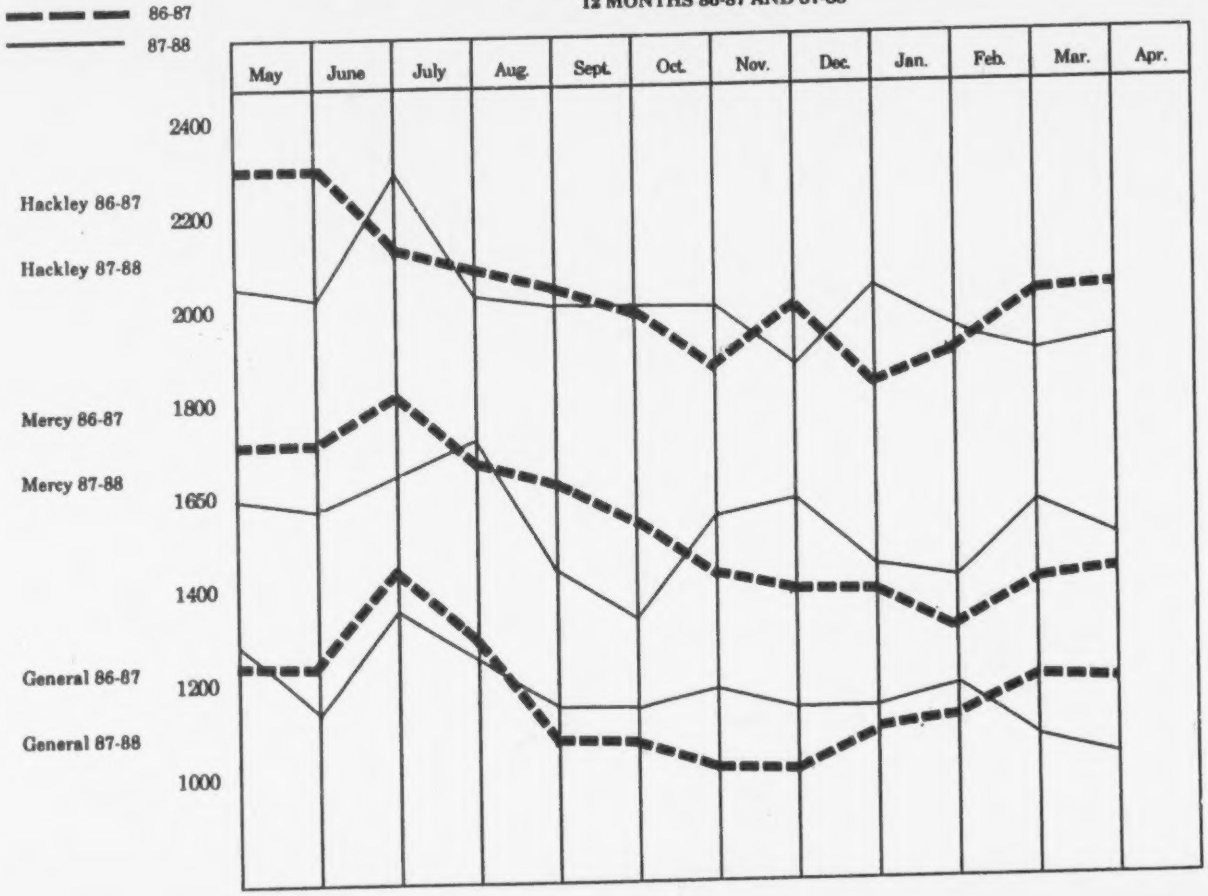
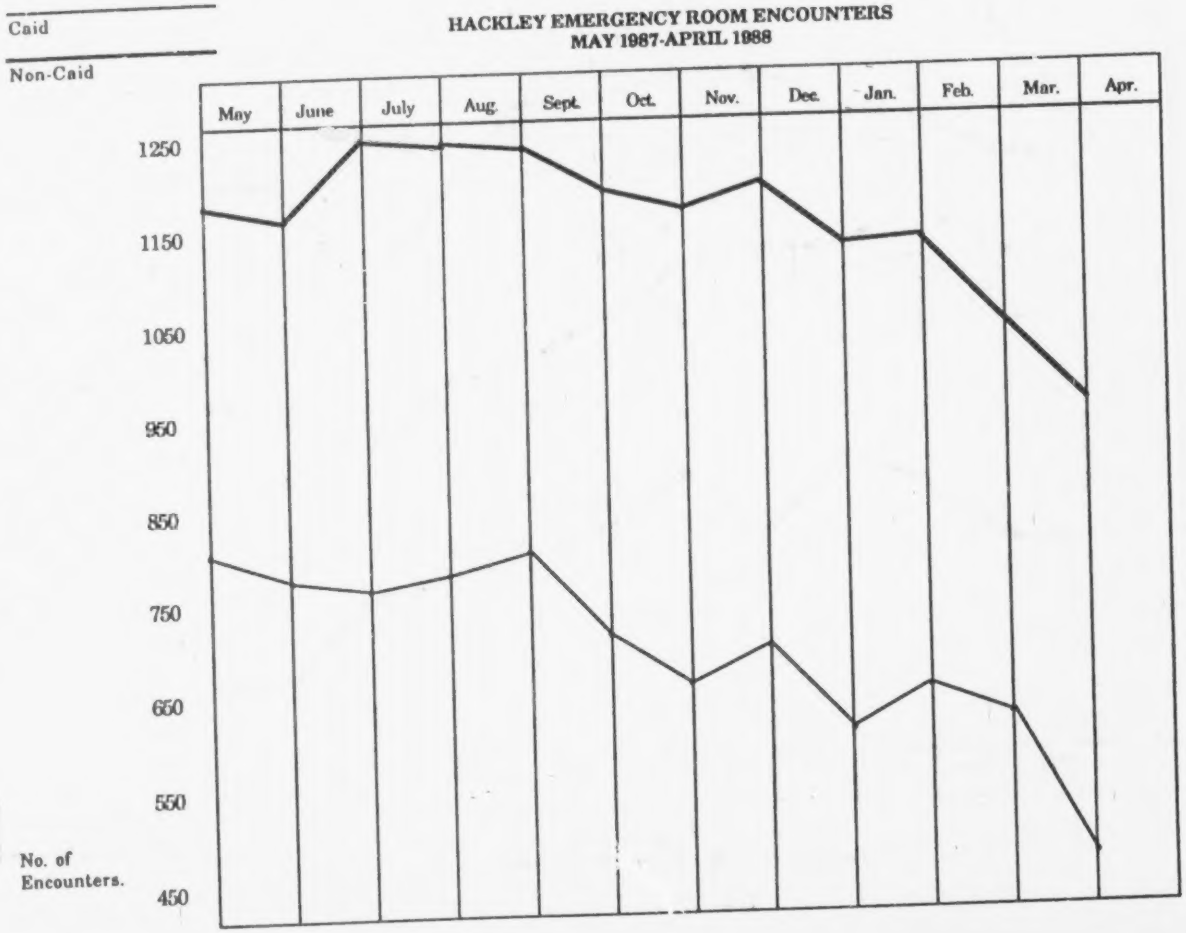


FIGURE 13



HACKLEY EMERGENCY ROOM ENCOUNTERS
MAY 1987-APRIL 1988

FIGURE 1

HACKLEY EMERGENCY ROOM ENCOUNTERS
MAY 1987-APRIL 1988
INDIGENT VS. NON-INDIGENT
MINOR TREATMENT ENCOUNTERS

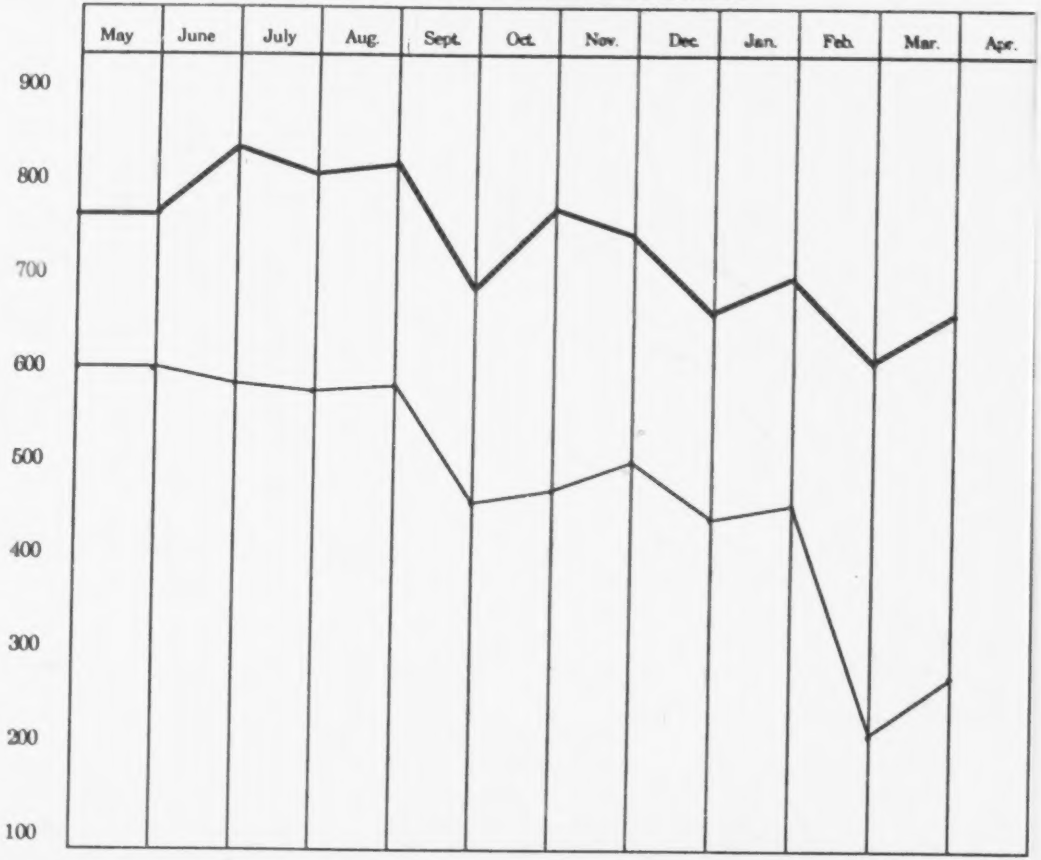


FIGURE 15

% OF INDIGENT OR NON-INDIGENT REQUIRING MINOR TREATMENT

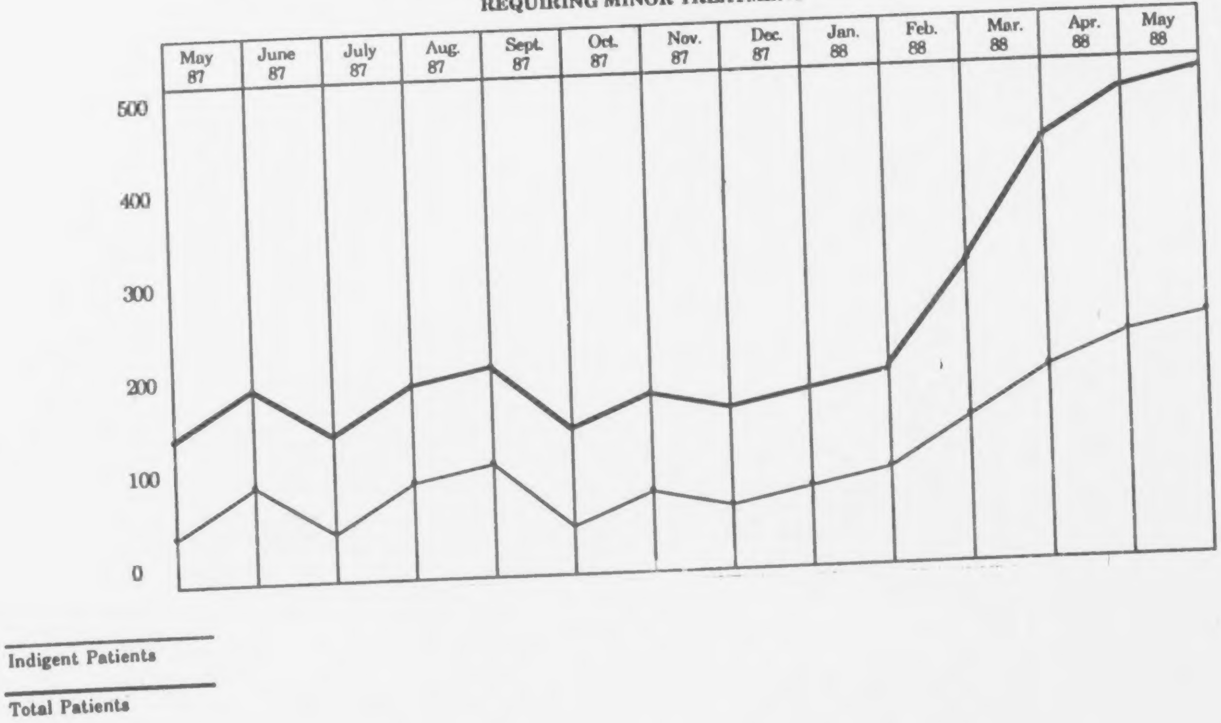


FIGURE 16

PANEL PATIENTS ENCOUNTERS
HACKLEY HOSPITAL MAY 1987-JUNE 1988

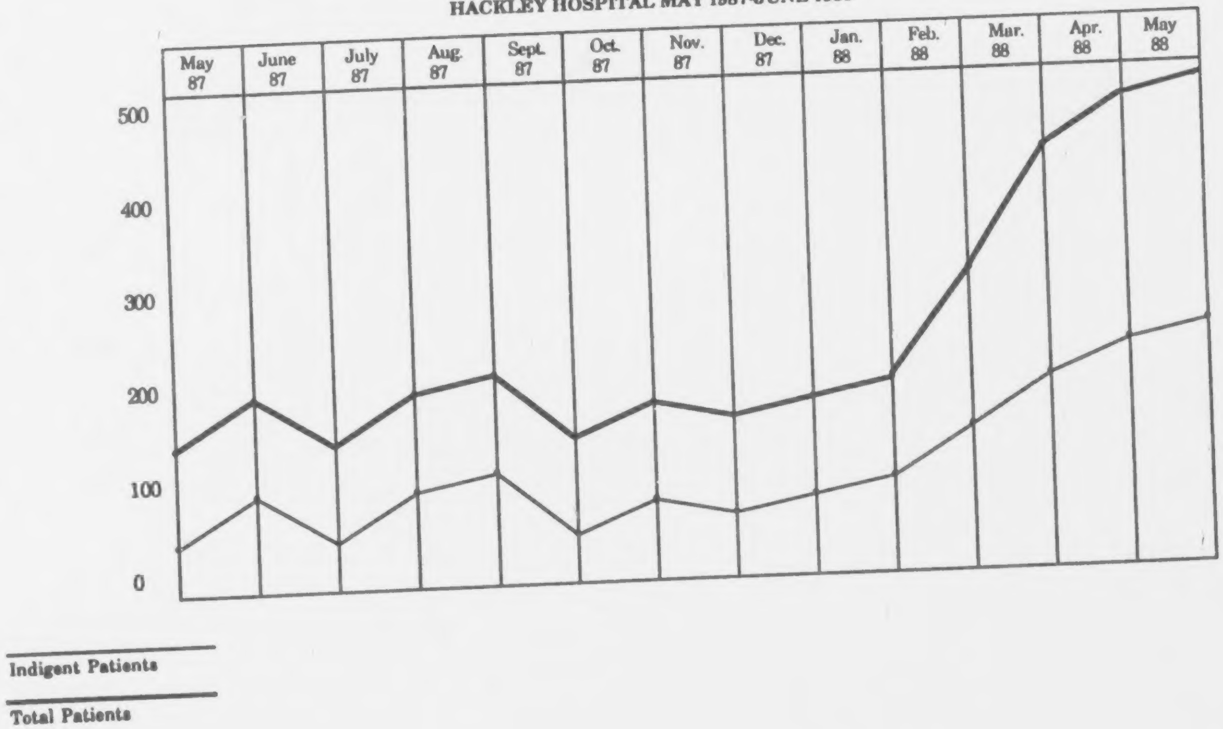
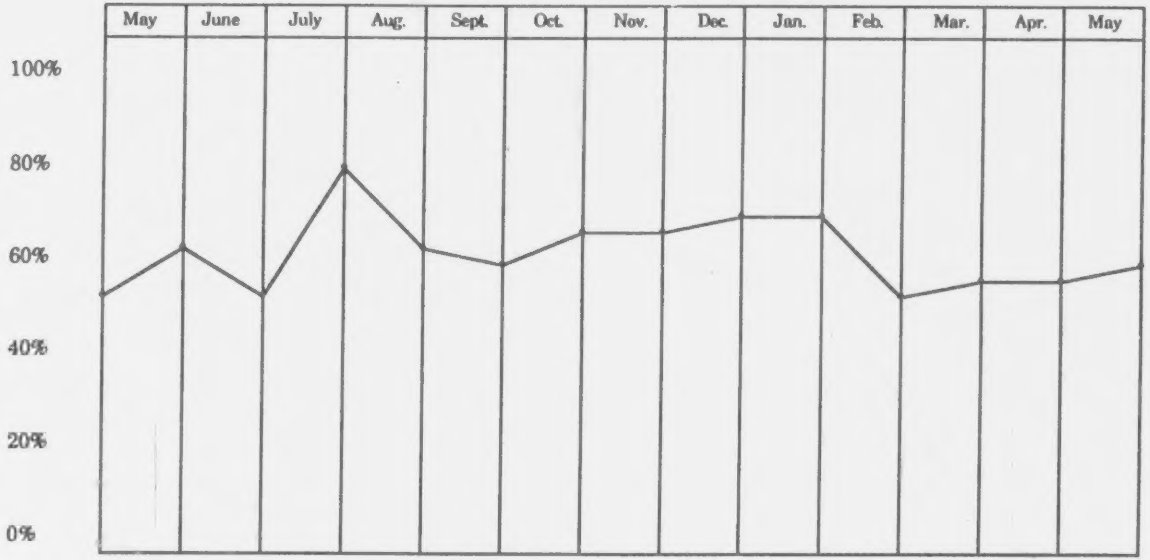


FIGURE 17

PANEL PATIENTS HACKLEY E.R.

%OF INDIGENT ENCOUNTERS TO TOTAL ENCOUNTERS



In 14 months has stayed in 50% - 60% range 11 months.

ANALYSIS

Both the physicians'questionnaire and the telephone survey indicate that there is an inadequate supply of primary care physicians in Muskegon County. It is difficult, sometimes impossible, for a Medicaid patient to get a family physician.

The anecdotal data agrees that the major shortage is primary care. There is no data that indicates referral physician services are not available as needed, with one exception.

That exception is Obstetrics / Gynecology. While we have no indication that service has not been provided; the obtaining of such service has often required negotiation by someone other than the patient.

Demand continues, unabated. The Medicaid population of Muskegon County is 13% of the county population.

Assuming a total physician population of 200, the assumption could be made that the full time services of 26 physicians would be needed to supply the medical needs of the Medicaid population.

With an annual growth rate in the Medicaid population of 6%, the county would need to add the full time equivalence of one additional physician each year.

Some of the patients have been able to obtain treatment elsewhere. There is no suggestion in the fragmentary data we have that these patients are going to med centers.

But the emergency room data presents a totally different picture. Medicaid patients, 13% of the county's population, were responsible for 38% of the encounters in the Hackley Emergency Room.

Panel patient counts were even more slanted. Again, assuming a Medicaid population of 13%, indigent patients were responsible for 55% of the total panel patient encounters in Hackley.

But the assumption that indigent patients abuse emergency room facilities is undercut by this data.

Figure 12, which plots use of all three ER rooms, shows a striking similarity of patterns of use. There can be no question but that the patterns of use are cyclical and all three institutions follow the same pattern. Figure 13 shows Hackley ER encounters and we again see a reoccuring cyclical pattern of use. Both indigent and non-indigent are strikingly similar. Figure 14 plots use for minor treatment encounters. If there was overuse by indigent patients it would appear in this graph, but instead we find the same cyclical pattern. In Figure 15 we have converted these encounters into percentages of minor treatments and we find almost identical pictures. This is corroborated by the Mercy data, which indicates a very low percentage of use for minor treatment.

Panel patient encounters for indigents are depicted in Figure 16. Again, the patterns were almost identical, but a sharp upswing in total utilization appeared from Februrary 1988 to June 1988. Although indigent usage went up also, it did not go as sharply upwards.

Figure 17 translates panel encounters of indigents as a percentage of total panel patient encounters. In 11 out of 14 months it stayed within 50% - 60% range of total panel encounters, strongly suggesting, as does all this data, that indigent panel patients use the emergency room in the same pattern as non-indigent patients.

RECOMMENDATION

We return to our original question --

"Do we need a clinic?"

Let us examine what is required to establish a clinic.

1. A structure and a means of payment for occupancy costs.

2. An organization and a means of meeting payrolls.

3. Physicians and a means of supplying them income.

The financial resources required have to be computed and budgets have to be set based upon the requirement of a projected number of patients.

Unfortunately, we do not know the precise number of patients such a clinic would serve.

We know there is a need for primary care physicians, especially family practitioners. From the evidence a reasonable assumption can be made that present need is for hundreds, not thousands of patients.

If so, treatment in physician offices would eliminate the need to fund the structure and part of the organization. The remaining task would be to provide payment for physician services.

This is the crux of the matter. The scarce supply -- family practitioners and OB/GYN specialists -- does not meet the demand. To obtain more supply, we must bluntly face the real solution; provide funds so that these groups are attracted to provide service.

A means of subsidy would have to be found that provided units of supply as demand was indicated. But supply would not be purchased or contracted for until need was evident.

Such a mechanism would cut costs sharply and tie them to actual need. It would eliminate need for capital investment. Physician subsidies would be the major budgetary requirement.

However, there are other factors to be considered. If the Koinonia patients were left without service, we would have to raise our planning sights. Thousands would require service and the need for a clinic structure would be paramount.

There are other elements to be considered -- The need for a family practice residency and the economic repositioning of hospitals are factors to be considered from a subsidy standpoint as well as an organizational standpoint.

There is need for more physicians' services for the indigent. The society must first decide if it wants to play an activist role in meeting this need. If so, many avenues are open; many decisions must be taken.

If not, there are other forces in the community who will attempt to fill the void. You must decide if you want others or the Muskegon County Medical Society to set the agenda.

10 JULY 1989

TO: THE HONORABLE DONALD W. RIEGLE, JR.
UNITED STATES SENATOR (MICHIGAN)

FROM: SFC JOHN N. MYRONIUK, MIARNG

SUBJECT: HEALTH CARE COVERAGE AND COSTS.

This letter is a follow up to my initial statement and written correspondence concerning Health Care Coverage and Costs on 28 June 1989, in Southfield, MI. Please find enclosed with this letter copies of my daughters' medical statements, partial history and organizations, which I have contacted in hopes of receiving some financial support or assistance, because the U.S. Military doesn't provide any assistance regarding my daughters' case.

Currently, a majority of organizations claim that Cerebral Palsy is a qualified condition and my daughters' current health problems; (ie: birth defects in hearing, eyes, dental, kidney and urinary tract.) All of which, are qualifying elements, however; certain guidelines must be met. Therefore, she doesn't qualify by reason of age, not handicapped enough or my yearly earnings are just over the limits.

Furthermore, I have been told verbally that if I give my daughter up for adoption or give legal guardianship/custody over to a relative for her, she will automatically qualify for food stamps, full medical coverage, and an additional monthly subsistance allowance for her handicapp, so adequate care can be provided. Yet, she can't qualify for any other programs as long as we remain a family unit. Presently, persons like my daughter are covered by Federal, State, and local laws governing adequate care rights for the handicapped. There again, insuring she receive everything possible or be removed from the family by the Department of Social Services, because care is not adequate. Its' astonishing to see how the system really functions and who it really supports. In my opinion, to much monies are wasted disqualifying persons, instead of assisting them where it is really needed. Also, a ceiling must be established on the costs of Health Care Services and Co-pay premeiums.

At this time, I'm still trying to receive some assistance for my family and I have nothing in stone, yet! I have another agency within the Department of Social Services of Macomb County exploring a few more avenues in hopes of resolving my situation. Presently, we have been promised some assistance through the Macomb County Department of Social Services, as of 3 July 1989. Furthermore, I explained that I contacted your office and Crippled Childrens' of Macomb County is now re-writing a new contract for us in hopes that it will resolve our problems. Therefore, I support and commend you Senator in your efforts to establish legislation for an adequate Health Care System that will be available to all persons, whether healthy, elderly, handicapped, or with chronic health related illnesses, and family members or dependents of the U.S. Military personnel covered under the CHAMPUS Health Program. I would like to see the improvement of coverage being offered or other new coverage be offered to dependents of military personnel with special needs or requirements that are not already covered, which is the category I fit in at the present time. Please feel free to contact me at Tel: (313)-739-1929 or (313)-963-6608, regarding any further questions in this matter. Thank You for your time.

RESPECTFULLY SUBMITTED:

John N. Myroniuk

JOHN N. MYRONIUK
SFC, MI ARNG

MYRONIUK, CYNTHIA M.

MEDICAL INFORMATION SHEET

DR. CUKROWSKI (EYE)
4200 N. WOODWARD AVE
ROYAL OAK,MI. 48072 PH: 549-6000

DR. MANICA (NUEROLOGY)
755 W. BIG BEAVER RD
TOP OF TROY SUITE 245
TROY,MI. 48084 PH: 362-1520

DR. A. SANDOVAL (PEDITR)
43391 COMMONS DR.
MT CLEMENS,MI. 48044 PH: 263-0970

DR. BELENKY (ENT)
22631 GREATER MACK
ST CLAIR SHORES,MI. 48080 PH: 778-4433

DR. REITELMAN (UROLOGY)
CHILDRENS HOSPITAL (DET)
3901 BEAUBIN
DETROIT,MI. 48201 PH: 745-5588

FRANKS PHARMACY
43071 HAYES RD
STERLING HTS,MI. 48078 PH: 247-5411

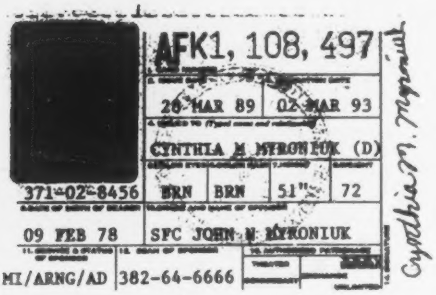
ST JOSEPH HOSPITAL
15855 19 MILE RD
MT CLEMENS,MI. PH:263-2300

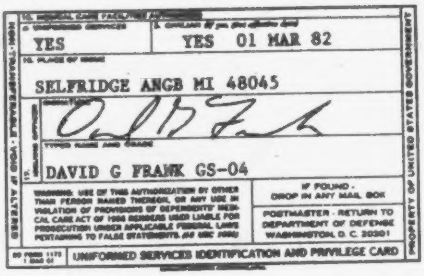
MACOMB PHYSICAL THERAPY & REHAB
43421 GARFIELD SUITE 6
MT CLEMENS,MI. 48044
PH: 286-8280

DR. HURVITZ (PHY MED)
DEPT OF PHY-MED & REHABILITATION
U of M HOSPITAL 1D204
ANN ARBOR,MI. 48109-0042
PH: OFFICE 936-7200 APPT 936-7182

DR. REYNOLDS (UROLOGY TESTING)
24500 NORTHWESTERN HWY
SOUTHFIELD,MI. 48075 PH:353-1280

EASTER SEALS of MACOMB COUNTY
39093 HARPER
MT CLEMENS,MI. 48045 PH:468-7000


[redacted]
AFK1, 108, 497
20 MAR 89
02 MAR 93
CYNTHIA M MYRONIUK (D)
371-02-8456
BRN
BRN
51"
72
09 FEB 78
SFC JOHN M MYRONIUK
MI/ARNG/AD
382-64-6666
Cynthia M. Myroniuk


NON-TRANSFERABLE · VOID IF ALTERED
YES
YES 01 MAR 82
SELFRIDGE ANGB MI 48045
TYPED NAME AND GRADE
DAVID G FRANK GS-04
WARNING: USE OF THIS AUTHORIZATION BY OTHER THAN PERSON NAMED THEREON, OR ANY USE IN VIOLATION OF PROVISIONS OF DEPENDENTS' MEDICAL CARE ACT OF 1956 RENDERS USER LIABLE FOR PROSECUTION UNDER APPLICABLE FEDERAL LAWS PERTAINING TO FALSE STATEMENTS (18 USC 1001)
IF FOUND - DROP IN ANY MAIL BOX
POSTMASTER - RETURN TO DEPARTMENT OF DEFENSE WASHINGTON, D.C. 20301
UNIFORMED SERVICES IDENTIFICATION AND PRIVILEGE CARD
PROPERTY OF UNITED STATES GOVERNMENT

Public Official's Statement

Beneficiary Name (Last, First, MI): MYRONIUK, CYNTHIA MARIE

Sponsor's Social Security Number: 382-64-6666

TYPES OF SERVICE	SERVICES REQUIRED	AVAILABILITY OF SERVICE FROM PUBLIC AGENCY *AVAILABLE	AVAILABILITY OF SERVICE FROM PUBLIC AGENCY NOT AVAILABLE
Audiology	☐	☐	☐
Diagnostic Tests/Evaluations	☐	☐	☐
Education (RTC Psychiatric)	☐	☐	☐
Special Education	☐	☒	☐
Residential Care (Non-Psychiatric)	☐	☐	☐
Nursing	☐	☐	☐
Occupational Therapy	☐	☒	☐
Physical Therapy	☐	☒	☐
Speech Therapy	☐	☐	☐
Durable Medical Equipment	☐	☐	☐
Hearing Aids	☐	☐	☐
Prosthetic Devices	☐	☐	☐
Other (Specify) ______	☐	☐	☐

*Describe the Extent, Type, Frequency and Funding of each Available Service

Direct special education instruction is provided according to IEP on 2 or more subjects. Resource room support as needed. Related services are listed below:

Speech & Language - 2 30 min sessions/wk.
Occupational Therapy - 1 30 min. session/wk.
Physical Therapy - 1 30 min session/wk.
School Social Worker - 2 30 min sessions/mo.

Name and Title of Public Official (Typed or Printed):
Burr Elementary Principal
Martin Kasiska

Public Agency's Name and Mailing Address:
Utica Community Schools
Burr Elementary
41460 Ryan Rd.
Sterling Hts, MI 48310 Zip Code

Signature of Public Official: Martin Kasiska

Phone Number: (313) 254-8339

Date: 6/5/89

CHAMPUS Form 769
October 1988

UNIVERSITY OF MICHIGAN MEDICAL CENTER

PHYSICAL MEDICINE AND
REHABILITATION ASSOCIATES

Date: May 4, 1989
Re: HYRONIUK, Cynthia
Reg No: 2106 231 5

Ms. Luann Coe
39660 Spalding
Sterling Heights, Michigan 48078

Dear Ms. Coe:

Cynthia Hyroniuk was seen in follow-up in the Phenol Block Clinic on May 04, 1989.

She underwent a Phenol block of the medial hamstrings of the gastrocnemii muscles on April 11, 1989. She has had a significant improvement in her gait. She is being seen by Edmund Turkon for Physical therapy. There have been tremendous problems with the school therapy according to the parents and he is a private therapist.

On examination today, Cynthia shows much less scissoring and much more normal pattern of gait. She had rather significant toe walking before and is now coming more down on the heels.

I feel that the blocks have been very successful. I would like her to continue getting therapy for the next several months to work on a normalization of her gait pattern and a better range of motion in her ankles and the knees.

I will see her again in two months to follow-up on her progress.

Sincerely,
DEPARTMENT OF PHYSICAL MEDICINE
AND REHABILITATION
Pediatric Adolescent Services

Edward Hurvitz

Edward Hurvitz, M.D.
Attending Physician

DD: 05-04-89
DT: 05-05-89
ATS:gw #4734

Business office: P.O. Box 8608, Ann Arbor, Michigan 48107 (313) 763-7130

Physicians' offices: 1500 E. Medical Center Drive
University Hospital, Room 1D204, Box 0042
Ann Arbor, Michigan 48109-0042

MAY 0 8 [illegible]

UNIVERSITY OF MICHIGAN MEDICAL CENTER

PHYSICAL MEDICINE AND
REHABILITATION ASSOCIATES

Date: May 4, 1989
Re: MYRONIUK, Cynthia
Reg No: 2106 231 5

Ms. Luann Coe
39660 Spalding
Sterling Heights, Michigan 48078

Dear Ms. Coe:

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She underwent a Phenol block of the medial hamstrings of the gastrocnemii muscles on April 11, 1989. She has had a significant improvement in her gait. She is being seen by Edmund Turkon for Physical therapy. There have been tremendous problems with the school therapy according to the parents and he is a private therapist.

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I feel that the blocks have been very successful. I would like her to continue getting therapy for the next several months to work on a normalization of her gait pattern and a better range of motion in her ankles and the knees.

I will see her again in two months to follow-up on her progress.

Sincerely,
DEPARTMENT OF PHYSICAL MEDICINE
AND REHABILITATION
Pediatric Adolescent Services

Edward Hurvitz

Edward Hurvitz, M.D.
Attending Physician

DD: 05-04-89
DT: 05-05-89
ATS:gw #4734

Business office: P.O. Box 8608, Ann Arbor, Michigan 48107 (313) 763-7130

Physicians' offices: 1500 E. Medical Center Drive
University Hospital, Room 1D204, Box 0042
Ann Arbor, Michigan 48109-0042

MAY [illegible]

..ty of Michigan
Medical Center

University of Michigan Hospitals
1500 East Medical Center Drive
Ann Arbor, Michigan 48109

March 2, 1989
Re: Myroniuk, Cynthia Marie
Reg No: 2106 231 5

Luann Coe
39660 Spalding
Sterling Heights, MI 48078

Dear Ms. Coe:

As you will recall, Cynthia Myroniuk was seen in the Physical Medicine and Rehabilitation Pediatrics Clinic on March 2, 1989. In summary, Cynthia is an eleven year old girl with a history of cerebral palsy which was diagnosed at age three. Cynthia was the product of a 37 week gestation of a diabetic mother, delivered by cesarean section due to fetal distress. She was under your care as her physical therapist for several years and became involved in a PO-HI until approximately two years ago. At that time she was mainstreamed into Burr School and receives physical therapy presently one time a week at most. Cynthia is presently seen at the Easter Seals Clinic. She underwent surgery for reconstruction of her duplicated kidney in December of 1988.

On physical examination we found Cynthia to be a very cooperative, alert, appropriate, eleven year old. Examination revealed a spastic diplegia with significant adductor tone and toe walking. We found no fixed contractions in her lower extremities. We were able to stretch both of her ankles past neutral. Her lower extremity adduction seemed to be related to medial hamstrings rather than adductor tone. Her hamstrings were only slightly tight.

We discussed with you and Cynthia's parents the procedure of a phenol motor point block. We reviewed the risks and benefits in Cynthia's case. We also briefly discussed the possibility of dorsal rhizotomy in the future, however we did not recommend this procedure at this time as Cynthia is functioning quite well. We feel that Cynthia would benefit from a motor point block of the medial hamstrings as well as the gastroc. We have scheduled her for this block and will see her back then, and we are available to answer any questions which you or her parents may have in the meantime.

Please feel free to contact us if we can be of any further assistance.

Sincerely,

Edward

Edward Hurvitz, M.D.
Attending Physician

Moon

M. Melissa Moon, D.O.
Resident Physician

0302 mp 03

Public Official's Statement

Beneficiary Name (Last, First, MI) MYRONIUK, CYNTHIA MARIE

Sponsor's Social Security Number 382-64-6666

TYPES OF SERVICE	SERVICES REQUIRED	AVAILABILITY OF SERVICE FROM PUBLIC AGENCY	
		*AVAILABLE	NOT AVAILABLE
Audiology	☐	☐	☐
Diagnostic Tests/Evaluations	☒	☑	☐
Education (RTC Psychiatric)	☐	☐	☐
Special Education	☐	☐	☐
Residential Care (Non-Psychiatric)	☐	☐	☐
Nursing	☐	☐	☐
Occupational Therapy	☒	☑	☐
Physical Therapy	☒	☑	☐
Speech Therapy	☐	☐	☐
Durable Medical Equipment	☐	☐	☐
Hearing Aids	☐	☐	☐
Prosthetic Devices	☐	☐	☐
Other (Specify) ______	☐	☐	☐

*Describe the Extent, Type, Frequency and Funding of each Available Service

Evaluation Clinic - 3 times a year
O.T. and P.T. - once a week
Our Clinic and Services are free.

Name and Title of Public Official (Typed or Printed)

Public Agency's Name and Mailing Address
Easter Seal Society of Macomb County
39093 Harper Avenue
Mt. Clemens, MI.
Zip Code 48043

Signature of Public Official Richard N. Meade

Phone Number (313) 468-7000

Date 6/9/89

CHAMPUS Form 769
October 1988

ROBERT J. McDONALD, M. D.
WALTER S. CUKROWSKI, M. D.

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS

4200 NORTH WOODWARD AVENUE
ROYAL OAK, MICHIGAN 48072
TELEPHONE (313) 549-6000

September 24, 1988

RE: Cynthia Myroniuk

TO WHOM IT MAY CONCERN:

Cynthia has been followed in our office since February of 1978. The child has been diagnosed to have cerebral palsy and has been followed in our office because of an esotropia as well as an amblyopia. She has had several eye operations in order to correct the muscle imbalance. She also has worn a patch, has used Atropine for her amblyopia. The last visit to this office was on September 8, 1988 and we found that her uncorrected vision was found to be 20/40 in the right eye and about 20/30 in the left. Using the two eyes together the vision was 20/30. She presentl has a latent nystagmus, a variable exotropia at distance as well as near, and the refraction revealed the child to be farsighted with some astigmatism. The best corrected vision was found to be 20/30 in the right eye and 20/25 in the left. The fundus exam did reveal the discs to be slightly pale.

Sincerely yours,

W. S. Cukrowski MD

Walter S. Cukrowski, M.D.

WSC/nem

Dictated but not read.

The Power To Overcome

Easter Seal Society of Macomb County

39093 Harper Avenue
Mt. Clemens, Michigan 48043
(313) 468-7000

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Frank Pravato
Romeo
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Christian Herrmann
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Warren South
Janet Herring
Jack Turner
At Large
JoAnn Hoogs-Doman
Clarence Harms
Rick Paul
MEDICAL STAFF
James B. Anderson, M.D.
Orthopaedic Surgeon
John V. Corbett, M.D.
Orthopaedic Surgeon
Carl L. Hukin, M.D.
Orthopaedic Surgeon
Michael E. Tofteland, M.D.
Orthopaedic Surgeon
Karen M. Cirillo, O.T.R.
Occupational Therapist
OFFICE MANAGER
Nancy Hobbies
MEDICAL SECRETARY
Barbara Valentine
DEVELOPMENT SPECIALISTS
Leese Paul
Janet A. Sullivan
EXECUTIVE DIRECTOR
Richard A. Meade

April 19, 1989

Burr Elementary School
41460 Ryan
Sterling Heights, MI. 48078

RE: Cindy Myroniuk

To Whom It May Concern,

Cindy Myroniuk has been seen at the Easter Seal Clinic for a number of years. She has cerebral palsy of a spastic diplegia type and needs to continue physical therapy with gait and balance training, improvement in range of motion of the lower extremities and strengthening of muscle and also improvement of gross motor skills.

Very truly yours,

John V. Corbett, M.D. N.H.

John V. Corbett, M.D.
Orthopedic Surgeon

JVC/nh

UTICA COMMUNITY SCHOOLS
Special Services

INDIVIDUALIZED EDUCATION PLANNING COMMITTEE REPORT

SECTION I (IEPC)

ALL ITEMS MUST BE FILLED IN FOR COMPLIANCE PURPOSES.

Date of IEPC Meeting 4-20-87

Student Legal Name [illegible] Birthdate [illegible]-78

Resident District Utica Home School Burr

Operating District Utica Attending School Burr

Home Address [illegible] City Utica Zip 48087

Nat. Lang. of Student ______ Lang. Spoken in Home Eng. Race C Grade [illegible] Sex [illegible]

Parent (s) or Guardian (s) [illegible] Home Tel ([illegible]) [illegible]

Address of Parent (s) (if different) ______ Work Tel ( ) ______

PARENT NOTIFICATION: ✓ By Letter ___ By Phone ___ Other Date [illegible]-87

PURPOSE OF I.E.P.C.

___ Initial ___ Annual Review ✓ Review of 3 year Comprehensive Evaluation

Change of Educational Status (Reason) ______

NAMES OF COMMITTEE MEMBERS (Signature indicates participation)

Parent/Legal Guardian [illegible] Resident District Rep [illegible]

Parent/Legal Guardian [illegible] Operating District Rep ______

Student (If appropriate) ______ Special Education Teacher [illegible]

M-Team Representative [illegible] General Education Teacher Sandra K. Ela[illegible]

Other (with title) [illegible] Other (with title) ______

Other (with title) [illegible] SSW Other (with title) [illegible]

NOTE Any participant who disagrees with the IEPC Committee's recommendations has the right to attach a dissenting opinion to this report.

CURRENT M-TEAM DATED: 4-13-87

Evaluations Included:

✓ Psychological
✓ Speech/Language
✓ Social Work

___ Teacher Consultant
✓ Special Education Teacher
✓ General Education Teacher

Other Occupational Therapist
Physical Therapist
Medical Rpt.
[illegible]

Date of Next M-Team Report ______

Form 2728 — 03-01-88 DISTRIBUTION White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

Student Name Cynthia [illegible] B.D. 2/9/78 Date 4/20/87

SECTION II — CURRENT PERFORMANCE, ELIGIBILITY AND LEAST RESTRICTIVE ENVIRONMENT

CURRENT LEVEL OF EDUCATIONAL PERFORMANCE:

Academic Achievement: Woodcock Johnson: Read. SS 79 [illegible], Math SS 72 [illegible] [illegible]

Report Card Grades: WRAT Rd. 28 [illegible] Math 36 [illegible] Card: Rd. 3, Sp. A-, Eng. B+, Math C, Sci. B-

Intellectual: WISC-R [illegible] IQ 87 [illegible] Math [illegible] IQ [illegible] 77

Pre-Vocational & Vocational (age 12 and up) NA

Social & Emotional Adjustment: Age Appropriate. Increase in socialization

Daily Living Skills: adequate for [illegible]

Psychomotor Skills: [illegible] - see occupational + physical therapy

Communication Skills: [illegible]

Additional Relevant Information: Parents have provided a medical report. [illegible] with [illegible] - see reports attached

ELIGIBILITY

Based on current performance and the M-Team dated [illegible], the IEPC determines this person to be:

✓ Eligible ______ Ineligible — for special education programs and/or services according to the characteristics found in Rule Number:

___ R340.1703 SMI	___ R340.1706 EI	✓ R340.1709 POHI	___ R340.1713 LD
___ R340.1704 TMI	___ R340.1707 HI	___ R340.1710 SPL	___ R340.1714 SXI
___ R340.1705 EMI	___ R340.1708 VI	___ R340.1711 PPI	___ R340.1715 AI

Secondary Impairment: Speech Language Impairment ☒ Yes ☐ No Rule Number 340.1710

LEAST RESTRICTIVE ENVIRONMENT: Each option must be considered until an acceptable one is determined

	PROGRAM OPTION	ACCEPT/REJECT (Use "A" or "R")	REASON
✓	Regular Classroom	R	[illegible]
___	Regular Classroom with Teacher Consultant	R	
___	Regular Classroom and Resource Room	A	[illegible]
___	Regular Classroom and Part-time Special Education Categorical Classroom		
___	Special Education Categorical Classroom and Part-time Regular Education Classroom		
___	Special Education Categorical Classroom-Full time		
___	Special Education Categorical Classroom-Outside District (specify) ______		
___	Other (specify) ______		

Page 3 of 5

Student Name Cynthia [illegible] B.D. 2/9/72 Date 4/20/79

SECTION III – PLACEMENT AND SERVICES

SPECIAL EDUCATION PROGRAMS – Use A, B or C (Check one only)

Is the secondary program departmentalized (R340.1749 c)? ☐ Yes ☐ No

☐ A. **CATEGORICAL PROGRAM: 3 OR MORE BASIC INSTRUCTIONAL CLASSES**

____R340.1738 SMI	____R340.1741 EI	____R340.1744 POHI	____R340.1754 PPI
____R340.1739 TMI	____R340.1742 HI	____R340.1747 LD	____R340.1756 SLI
____R340.1740 EMI	____R340.1743 VI	____R340.1748 SXI	____R340.1758 AI

Name of Primary Provider ____

NOTE: If the above categorical program does not correspond with the student's primary impairment category, the IEPC must provide a rationale for the alternative program. The parent/guardian must consent to this alternative program as specified by their signature in the space provided below. If the parent/guardian does not consent, the student must be placed in a program that corresponds to his/her primary impairment or the district must initiate due process procedures to determine the appropriate program. RATIONALE: ____

Parent Signature ____

Total Hrs. in School Day ____ Hrs. in Spec. Ed. ____ Hrs. in Reg. Ed. ____ FTE (Sp. Ed.) ____% Duration* ____

☑ OR B. **RESOURCE ROOM: 2 OR LESS BASIC INSTRUCTIONAL CLASSES**

☑ Elementary R340.1749a ☐ Secondary R340.1749b

Circle Teacher Endorsement(s) LD [✓ EI] MI Other ____

Name of Primary Provider [illegible]

If none of the above endorsements correspond with the student's primary impairment category, teacher consultant services must be considered for the resource teacher.

Are these consultant services needed? ☐ Yes ☑ No

Total Hrs. in School Day 6 Hrs. in Spec. Ed. 1-2 Hrs. in Reg. Ed. 4-5 FTE (Sp. Ed.) 20-30 % Duration* [illegible] - 6/?/79 [illegible] - 11-27/79

☐ OR C. **TEACHER CONSULTANT (R340.1749)** Sessions Per Wk./Mo. ____ Length of Session ____ Duration* ____

Circle Teacher Consultant Endorsement(s) LD EI MI Other ____

Name of Primary Provider ____

RELATED SERVICES DETERMINED TO BE APPROPRIATE:

	Sessions per Wk/Mo	Length of Session	Duration*
✓ Speech & Language R340.1745	2/wk.	20-30 min.	School year.
✓ School Social Worker R340.1701(d)(v)	2/mo.	30 min.	" " "
____ Psychologist R340.1151			
____ Work Study R340.1733(m)			" " "
✓ Occupational Therapy R340.1701a(l)	1/wk.	30 min.	
✓ Physical Therapy R340.1701a(m)	1/wk.	25-30 min.	
____ Homebound-Hospitalized R340.1746			
____ Other ____			

Physical Education R340.1701a(n) ☐ No ☑ Yes ☑ Regular ☐ Adaptive Explanation ____

Transportation R340.1701(d)(iv) ☑ No ☐ Yes ☐ Additional ☐ Specialized ☐ Form 2521 attached

Course of Study: (Check one only)

✓ Regular education curriculum leading to a high school diploma with special education support services

____ Special education curriculum (ISD approved) leading to a high school diploma that includes physical education, personal adjustment, pre-vocational and vocational training.

Prevocational/vocational education was considered: ☐ Yes ☐ No Recommendation ____

Vocational evaluation has been completed: ☐ Yes Date ____ ☐ No Recommendation ____

Vocational Education program determined to be appropriate ____ Regular ____ Adapted ____ Special Needs (S.C.O.R.E.)

____ Work Study ____ Shared-Time ____ Lutz Center ____ Referred to Michigan Rehabilitation Services: Date ____

Anticipated Date of Graduation ____

*NOTE: ALL SERVICES RECOMMENDED AT THIS IEP ARE PROVIDED WITHIN UTICA COMMUNITY SCHOOLS' REGULAR SCHOOL CALENDAR, NOT TO EXCEED ONE YEAR FROM THE DATE OF THIS IEP.

Form 2729a — 03-01-88 DISTRIBUTION: White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

Page 4a of 5

Student Name Cynthia Myroniuk **B.D.** 2/9/78 **Date** 4/27/89

SECTION IV – GOALS AND OBJECTIVES

DIRECTIONS: Please code each Annual Goal and Instructional Objective with the Evaluation Criteria, Procedure (s) and Schedule (s) to be used.

CRITERIA (C)
1. 80%, 4/5, 8/10
2. Mastery of 80 % of selected performance objectives.
3. ______
4. ______

(4) *Modification with 30% of sci and soc. stud. goals/objs as selected for ea. unit.

PROCEDURES (P)
1. Teacher made materials
2. Report card grades
3. Observation
4. Unit tests/mag tests
5. Daily Assignments
6. Interview
7. Demonstration on standardized instrument-list below:
8. WRAT
9. ______
10. ______

SCHEDULES (S)
1. Annually
2. Semi-annually
3. Quarterly
4. Monthly
5. Weekly
6. Daily
7. ______
8. ______

ACADEMIC SUPPORT
The Student Will Learn:

		C	P	S
AG I.	REGULAR EDUCATION SUBJECTS	1,4	1,2,7	1,5
IO A.	Complete class assignments and tests	↓	↓	↓
IO B.	Organize school day/routine/expectations	↓	↓	↓
IO C.	Follow school procedure and rules	↓	↓	↓
IO D.	Use special equipment/materials to complete assignments	↓	↓	↓
IO E.				

LANGUAGE ARTS
The Student Will Improve:

		C	P	S
AG I.	PRE/READING SKILLS			
IO A.	Pre/Sight vocabulary			
IO B.	Pre/Decoding skills			
IO C.	Pre/Comprehension skills			
IO D.	Pre/Reference and study skills			
IO E.	Literary skills			
IO F.				
AG II.	WRITTEN LANGUAGE SKILLS			
IO A.	Handwriting skills			
IO B.	Pre/Spelling skills			
IO C.	Capitalization and punctuation skills			
IO D.	Grammar skills			
IO E.	Composition skills			
IO F.				
AG III.	ORAL LANGUAGE SKILLS			
IO A.	Communication/conversation skills			
IO B.	Group discussion skills			
IO C.	Direction and memory/listening skills			
IO D.	Conceptual language skills			
IO E.				

MATHEMATICS
The Student Will Learn:

		C	P	S
AG I.	PREMATH/MATH SKILLS	1,2	1,2,7	1,3,6
IO A.	Pre/Basic numeration skills			
IO B.	Addition skills	↓	↓	↓
IO C.	Subtraction skills	↓	↓	↓
IO D.	Multiplication skills	↓	↓	↓
IO E.	Division skills	↓	↓	↓
IO F.	Fraction skills	↓	↓	↓
IO G.	Time/calendar skills			
IO H.	Money skills			
IO I.	Measurement skills			
IO J.	Geometry skills			
IO K.	Decimal skills			
IO L.	Percent skills			
IO M.	Problem solving skills			
IO N.				

SCIENCE
The Student Will Learn:

		C	P	S
AG I.	LIFE SCIENCE			
IO A.	Cell structure, the scientific method, and the microscope			
IO B.	Plants			
IO C.	Animals			
IO D.	The human body			
IO E.	Ecology			
IO F.	Protists			
IO G.				
AG II.	EARTH SCIENCE			
IO A.	Weather, climate, seasons, air, and water			
IO B.	Geology			
IO C.	The solar system			
IO D.				
AG III.	PHYSICAL SCIENCE			
IO A.	Mechanics			
IO B.	Sound and light			
IO C.	Electricity, magnetism and heat			
IO D.				

SOCIAL STUDIES
The Student will Learn:

		C	P	S
AG I.	GEOGRAPHY			
IO A.	Local geography and community			
IO B.	State geography and people			
IO C.	U.S. geography			
IO D.	World geography and cultures			
IO E.				
AG II.	AMERICAN HISTORY			
IO A.	The settling of America			
IO B.	The Revolutionary War			
IO C.	The Westward Movement and industrialism			
IO D.	The Civil War			
IO E.	Immigration and industrial expansion			
IO F.	World War I and the Great Depression			
IO G.	World War II			
IO H.	The Cold War and International Conflict			
IO I.	Civil Rights			
IO J.	U.S. today			
IO K.				
AG III.	CIVICS/GOVERNMENT			
IO A.	Local government			
IO B.	State government			
IO C.	Federal government			
IO D.	Civic responsibilities and rights			
IO E.				

Page 2b of 3

Student Name Cindy [illegible] **B.D.** [illegible]-9-77 **Date** 4-20-79

GOALS AND OBJECTIVES

DIRECTIONS: Please code each Annual Goal and Instructional Objective with the Evaluation Criteria, Procedure (s) and Schedule (s) to be used

CRITERIA (C)
1 80%, 4/5, 8/10
2 Mastery of ________ % of selected performance objectives
3 within task
4 completion

PROCEDURES (P)
1 Teacher made materials
2 Report card grades
3 Observation
4 Unit tests/mag tests
5 Daily Assignments
6 Interview
7 Demonstration on standardized instrument-list below WORD
8 ________
9 ________
10 ________

SCHEDULES (S)
1 Annually
2 Semi-annually
3 Quarterly
4 Monthly
5 Weekly
6 Daily
7 ________
8 ________

AUDITORY	C	P	S
___ Expressive ___ Receptive			
[✓ AG] I Improves auditory processing and recall skills			
IO A Improves attending skills			
IO B Improves word retrieval skills			
[✓ IO] C Improved auditory sequencing skills	3	7,6	~~[illegible]~~ 1
[✓ IO] D Improves recall of detail	3	7,10	1
IO E Improves understanding of informal questions			
IO F			

SEMANTICS	C	P	S
___ Expressive ___ Receptive			
[✓ AG] I To increase knowledge and usage of word meaning			
[✓ IO] A Improves vocabulary skills appropriate for age and/or ability level	3	7	1
[✓ IO] B Improves or expands descriptive/conceptual vocabulary skills	3	7	1
IO C Improves semantic relationships: ___ antonyms, ___ synonyms, ___ homonyms ✓ multiple meaning of words, ___ analogies ___ modifiers, ___ categorization skills, ___ absurdities ambiguities, ___ figurative language	3	7	1
IO D			

SYNTAX	C	P	S
___ Expressive ___ Receptive			
AG I To improve comprehension and use of selected sentence patterns			
IO A Demonstrates use of correct word order			
IO B Demonstrates proper use of grammar appropriate for age and/or ability level			
IO C Demonstrates expansion of sentence length and complexity appropriate for age and/or ability level			
IO D			

PRAGMATICS	C	P	S
___ Expressive ___ Receptive			
AG I Acquires functional/social language skills			
IO A Demonstrates intent to communicate			
IO B Demonstrates ability to communicate needs and wants			
IO C Demonstrates ability to expand on a topic			
IO D Demonstrates an awareness to listener's communicative needs: cueing, turn taking and clarification			
IO E Improves personal and school communication skills			
IO F Gains and shares information			
IO G Improves problem solving and/or reasoning skills			
IO H			

AUGMENTATIVE PROCEDURES	C	P	S
___ Expressive ___ Receptive			
AG I The student will demonstrate improvement in using augmentative procedures/equipment for learning			
IO A The student will learn to use communication boards			
IO B The student will learn to use electronic devices/computers to communicate/learn			
IO C			

OTHER ________	C	P	S
___ Expressive ___ Receptive			
AG I			
IO A			
IO B			

Form 5828b — 03-01-88 DISTRIBUTION White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

Page 4c of 5

Student Name Cindy [illegible] **B.D.** [illegible] **Date** Apr. 26, 1989

SECTION IV – GOALS AND OBJECTIVES

DIRECTIONS: Please code each Annual Goal and Instructional Objective with the Evaluation Criteria, Procedure (s) and Schedule (s) to be used.

CRITERIA (C)
1. 80%, 4/5, 8/10
2. Mastery of ________ % of selected performance objectives
3. ________
4. ________

PROCEDURES (P)
1. Teacher made materials
2. Report card grades
3. Observation
4. Unit tests/mag tests
5. Daily Assignments
6. Interview
7. Demonstration on standardized instrument-list below
8. [illegible]
9. ________
10. ________

SCHEDULES (S)
1. Annually
2. Semi-annually
3. Quarterly
4. Monthly
5. Weekly
6. Daily
7. ________
8. ________

MOTOR SKILLS

The Student will Learn/Improve/Maintain		C	P	S
FINE MOTOR				
AG I.	BASIC ARM AND HAND MOVEMENTS			
IO A.	Ability to move all parts of arms and hands			
IO B.	Reaching skills			
IO C.	Ability to grasp and release objects			
IO D.				
AG II.	OBJECT MANIPULATION AND BILATERAL HAND COORDINATION			
IO A.	Ability to manipulate objects, primarily using one hand (e.g., stacking, turning and inserting objects)	/	/	/
IO B.	Bilateral hand coordination (e.g., opening, assembling, cutting)			
IO C.	Uses scissors			
IO D.				
AG III	PERCEPTUAL MOTOR SKILLS			
IO A.	Visual tracking/visual perceptual skills (e.g., puzzles, patterns)	/	/	/
IO B.	Tactile perceptual skills			
IO C.	Body image/spatial relations	/		/
IO D.				
AG. IV	PRE-WRITING AND EARLY HANDWRITING SKILLS			
IO A.	Pre-writing skills			
IO B.	Early handwriting skills			/
IO C.				
AG V	IMPROVE MOVEMENT PATTERNS			
IO A.	Flexion posture			
IO B.	Extension posture			
IO C.	Contralateral arm and leg			
IO D.	Assumes sitting patterns			
IO E.	Maintain sitting posture			
IO F.	Kneeling			
IO G.				
AG VI	EQUILIBRIUM REACTIONS			
IO A.	In sitting			
IO B.	In a point			
IO C.	In standing			
IO D.	Protective extension reactions			
IO E.				
The Student Will Learn/Improve/Maintain				
GROSS MOTOR				
AG I	PRE-AMBULATORY MOBILITY			
IO A	Head Control/movement			
IO B	Trunk control/movement			
IO C	Extremity control/movement			
IO D	Rolling			
IO E	Crawling/creeping			
IO F	Transitional movements into/out of developmental postures			

		C	P	S
IO G	Squat and/or stand			
IO H	Kneeling/standing			
IO I				
AG II	AMBULATORY MOBILITY			
IO A	Gait			
IO B	Stair/ramp negotiation			
IO C	Ball skills			
IO D	Jumping/hopping/skipping skills			
IO E	Running			
IO F	Bicycles			
IO G				
AG III	RANGE OF MOTION			
IO A	Upper extremity ROM			
IO B	Lower extremity ROM			
IO C	Trunk			
IO D				
AG IV	STRENGTH			
IO A	Upper extremity strength			
IO B	Lower extremity strength			
IO C	Neck/trunk strength			
IO D				
AG V	BALANCE AND PROXIMAL STABILITY			
IO A	Prone on elbows			
IO B	Sidelying			
IO C	Sitting			
IO D	Four point			
IO E	Kneeling			
IO F	Half-kneel			
IO G	Standing			
IO H	Protective extension reactions			
IO I				
AG VI	BODY SYMMETRY			
IO A	Alignment			
IO B	Posture			
IO C				
AG VII	MOTOR PLANNING			
IO A	Imitates postures			
IO B	Follows verbal direction			
IO C	Transfers			
IO D				
AG VIII	ADAPTIVE EQUIPMENT			
IO A	A wheelchair			
IO B	A walker			
IO C	Crutches/cane			
IO D	Brace/splint			
IO E	Adaptive devices (e.g. prosthetic hand)			
IO F	Orthodics (e.g. body jacket, extremity bracing)			
IO G	Alternative positioning (seating, standing)			
IO H	Augmentative device			
IO I				

Form 2730c — 03-01-88 DISTRIBUTION White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

Page 4b of 5

Student Name Cindy Myraiolc **B.D.** ____________ **Date** ____________

SECTION IV – GOALS AND OBJECTIVES

DIRECTIONS: Please code each Annual Goal and Instructional Objective with the Evaluation Criteria, Procedure (s) and Schedule (s) to be used

CRITERIA (C)
1. 80%, 4/5, 8/10
2. Mastery of ________ % of selected performance objectives.
3. ____________________
4. ____________________

PROCEDURES (P)
1. Teacher made materials
2. Report card grades
3. Observation
4. Unit tests/mag tests
5. Daily Assignments
6. Interview
7. Demonstration on standardized instrument-list below: ____________________
8. ____________________
9. ____________________
10. ____________________

SCHEDULES (S)
1. Annually
2. Semi-annually
3. Quarterly
4. Monthly
5. Weekly
6. Daily
7. ____________________
8. ____________________

SOCIAL/EMOTIONAL

The Student Will Improve:

		C	P	S
AG I.	SELF CONCEPT			
IO A.	Self-esteem and positive feelings			
IO B.	Expressing feelings appropriately			
IO C.	Relating successfully in a group	/		
IO D.				
AG II.	INTERPERSONAL RELATIONSHIPS			
IO A.	Positive communication			
IO B.	Peer/adult interaction			
IO C.				
AG III.	WORK HABITS AND STUDY SKILLS			
IO A.	Identification with learning			
IO B.	Independent work habits			
IO C.	Following classroom rules/procedures			
IO D.				
AG IV.	INDEPENDENT AND RESPONSIBLE BEHAVIOR			
IO A.	Socially accepted behavior			
IO B.	Self-control and responsibility			
IO C.	Initiative and assertiveness			
IO D.	Class/school attendance			
IO E.				

INDEPENDENT/FUNCTIONAL LIVING

The Student Will Learn/Use:

		C	P	S
AG I.	SELF CARE SKILLS			
IO A.	Eating skills			
IO B.	Toileting skills			
IO C.	Dressing skills			
IO D.	Personal grooming skills			
IO E.				
AG II.	INDEPENDENT/FUNCTIONAL SKILLS FOR COMMUNITY LIVING			
IO A.	Health and safety skills			
IO B.	About family living			
IO C.	Homemaking skills			
IO D.	Personal business/management skills			
IO E.	Use of community transportation/facilities			
IO F.	Leisure time/recreational skills			
IO G.				
AG III.	ALTERNATIVE LEARNING EQUIPMENT			
IO A.	To type			
IO B.	To operate computer			
IO C.				

CAREER PREPARATION

The Student Will Improve:

		C	P	S
AG I.	PREVOCATIONAL SURVIVAL/COGNITIVE SKILLS			
IO A.	Communicating personal information			
IO B.	Survival reading and writing			
IO C.	Consumer math skills			
IO D.	Simple computer skills			
IO E.				
AG II.	APPROPRIATE WORK ENTRY/MATURITY SKILLS			
IO A.	Employment readiness			
IO B.	Job-seeking skills			
IO C.	Appropriate employee/employer skills			
IO D.	Work/class attendance			
IO E.				
AG III.	PREVOCATIONAL WORK SKILLS			
IO A.	Use of common household tools			
IO B.	Food service skills			
IO C.	Clerical skills			
IO D.	Lawn care skills			
IO E.	Housekeeping/cleaning skills			
IO F.				

VOCATIONAL EDUCATION: WORK STUDY/INDIVIDUAL VOCATIONAL TRAINING

The Student Will Learn/Improve:

		C	P	S
AG I.	PARTICIPATES IN WORK STUDY/INDIVIDUAL VOCATIONAL TRAINING PLAN			
IO A.	Job entry level clerical skills			
IO B.	Job entry level housekeeping/maintenance skills			
IO C.	Job entry level laboratory assistant skills			
IO D.	Job entry level laundry aide skills			
IO E.	Job entry level food service skills			
IO F.	Job entry level stock and packaging skills			
IO G.	Job entry level outdoor maintenance skills			
IO H.	Job entry level indoor maintenance skills			
IO I.	Job entry level nurse aide skills			
IO J.				
AG II.	APPROPRIATE WORK HABITS/MATURITY SKILLS			
IO A.	Employment readiness			
IO B.	Job seeking skills			
IO C.	Appropriate employer/employee skills			
IO D.				

Form 2730b — 03-01-88 DISTRIBUTION White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

MACOMB INTERMEDIATE SCHOOL DISTRICT • 12225 Masonic Blvd. • Warren, MI • 48093

MOBILE PHYSICAL THERAPY PROGRAM Auxiliary Service Center

Student Name Cinthia Muronuk **Birthday** 2 / 9 / 78 **Date** 4-20-89

School Burr El. **District** Utica **Grade** 3rd

Diagnosis Cerebral Palsy, Spastic Diplegia **RX Date** 3-88

Therapist Judi Wagner

Treatment Schedule: # 1 session per week

25-30 minutes per session.

Duration: April 1989 to April 1990 during scheduled Auxiliary Service Center school calendar.

Treatment will be based on the following:

I. **CRITERIA**

A. 80%, 4/5, 8/10

B. 70%, 7/10

C. 60%, 6/10, 3/5

D. ________ ________

E. ________ ________

II. **PROCEDURES**

[✓ A.] Observation

B. Demonstration on standardized instrument below

(Gross motor)

III. **EVALUATION**

[✓ A.] Annually

B. Semi-annually

C. Other ________

Current level of function Cinta requires guidance to perform range of motion [illegible] properly. [illegible] checklist

Comments: [illegible] to be [illegible] following [illegible] her physical activity.

Please Note: A current physical therapy prescription must be on file in order for this IEPC to be valid.

G273 ASC 1 IEPC Form 8/88

- MOBILE PHYSICAL THERAPY PROGRAM Auxiliary Service Center

Student Name Cynthia Myroniuk Date 4-20-89

GOALS AND OBJECTIVES

The student will learn/improve/maintain

		Criteria
*A.G.	I. PERCEPTUAL MOTOR	
**I.O.	A. Visual tracking/visual perceptual skills (e.g. puzzles, patterns)	
I.O.	B. Tactile perceptual skills	
I.O.	C. Body image/spatial relations	
I.O.	D.	
A.G.	II. IMPROVE MOVEMENT PATTERNS	
I.O.	[✓ A.] Flexion Posture	C
I.O.	[✓ B.] Extension Posture	C
I.O.	C. Contralateral arm and leg	
I.O.	[✓ D.] Assumes sitting patterns	B
I.O.	[✓ E.] Maintain sitting posture	E
I.O.	F. Kneeling	
I.O.	G.	
A.G.	III. EQUILIBRIUM REACTIONS	
I.O.	A. In sitting	
I.O.	B. In four point	
I.O.	C. In standing	
I.O.	D. Protective extension reactions	
A.G.	IV. PRE-AMBULATORY MOBILITY	
I.O.	A. Head control/movement	
I.O.	[✓ B.] Trunk control/movement	C
I.O.	[✓ C.] Extremity control/movement	C
I.O.	D. Rolling	
I.O.	E. Crawling/creeping	
I.O.	[✓ F.] Transitional movements into/out of developmental postures	C
I.O.	[✓ G.] Squat and/or stand	C
I.O.	[✓ H.] Kneeling/Standing	C
I.O.	I.	
A.G.	V. AMBULATORY MOBILITY	
I.O.	[✓ A.] Gait	C
I.O.	[✓ B.] Stair/ramp negotiation	C
I.O.	[✓ C.] Ball skills	C
I.O.	[✓ D.] Jumping/hopping/skipping skills	C
I.O.	[✓ E.] Running	C
I.O.	F. Bicycles	
I.O.	G.	

		Criteria
A.G.	VI. RANGE OF MOTION	
I.O.	[✓ A.] Upper extremity ROM	
I.O.	[✓ B.] Lower extremity ROM	
I.O.	[✓ C.] Trunk	
I.O.	D.	
A.G.	VII. STRENGTH	
I.O.	A. Upper extremity strength	
I.O.	B. Lower extremity strength	
I.O.	[✓ C.] Neck/Trunk strength	C
I.O.	D.	
A.G.	VIII. BALANCE AND PROXIMAL STABILITY	
I.O.	A. Prone on elbows	
I.O.	B. Sidelying	
I.O.	C. Sitting	
I.O.	[✓ D.] Four point	C
I.O.	E. Kneeling	
I.O.	[✓ F.] Half-kneel	C
I.O.	[✓ G.] Standing	C
I.O.	H. Protective extension reactions	
I.O.	I.	
A.G.	IX. BODY SYMMETRY	
I.O.	A. Alignment	
I.O.	[✓ B.] Posture	A
I.O.	C.	
A.G.	X. MOTOR PLANNING	
I.O.	[✓ A.] Imitates postures	A
I.O.	[✓ B.] Follows verbal direction	A
I.O.	C. Transfers	
I.O.	D. Scooter Board	
I.O.	E.	
A.G.	XI. ADAPTIVE EQUIPMENT	
I.O.	A. Wheelchair	
I.O.	B. Assistive devices	
I.O.	C. Brace/splint	
I.O.	D. Orthotics	
I.O.	E.	

* A.G. = Annual Goal

** I.O. = Instructional Objective

Therapist Signature

G 373 ASC 1 IEPC Forms 9/88

Page 5 of 6

Student Name [illegible] **B.D.** [illegible] **Date** [illegible]

SECTION V — AGREEMENT SIGNATURES

✓ The Utica Community Schools will implement this Individualized Education Program (IEP) at the Burr School, beginning [illegible] If not implemented within 15 calendar days: Explanation: ______

OR ______ The Utica Community Schools finds the student ineligible for Special Education Services.

OR ______ The Utica Community Schools would like to reconvene this I.E.P.C. meeting to discuss concerns of: ______ eligibility, ______ programs/services and/or ______ placement. Date of meeting (within 15 calendar days) ______

OR ______ The Utica Community Schools does not agree with this IEP and recommends that it not be implemented.

Additional Information: ______

[illegible] 4/20/87

Signature of Superintendent or Designee — Date

MINORITY OPINION:

Is there a dissenting report? ☒ No ☐ Yes By Whom ______

Report must be submitted to the Special Services Department within 7 calendar days of IEPC date, and becomes a part of the IEP.

TO BE USED ONLY WHEN OPERATING DISTRICT IS DIFFERENT FROM RESIDENT DISTRICT.

The Resident District:

______ agrees with this IEPC

______ does not agree with this IEPC's decision and requests that another IEPC meeting be held

______ hereby requests a Due Process Hearing.

Signature of Resident District Superintendent or Designee — Date

PARENT

✓ I have been fully informed of my Due Process Rights and understand that I have 7 calendar days in which to notify the Utica Community Schools that: (Check one only)

✓ I request that the Individualized Education Program (IEP)be implemented:

OR ______ I would like to reconvene this IEPC meeting to discuss concerns of: ______ eligibility ______ programs/services and/or ______ placement. Date of meeting (within 15 calendar days) ______

OR ______ I do not agree with the ______ report (s) of the Multidisciplinary Team report dated ______ and request Independent Educational Evaluation (s). Written objection attached? ☐ No ☐ Yes
Report of objection must be submitted to Special Services Department within 7 calendar days of IEPC Date and becomes part of the IEP

OR ______ I do not agree with the IEPC decision and request a Due Process Hearing related to: ______ eligibility, ______ programs/services and/or ______ placement.

[illegible]

Signature of Parents (s)/Legal Guardian (s) — Date

Form 2731 — 03-01-88 DISTRIBUTION White — Special Services Green — M-Team Yellow — Building Pink — Parent Gold — Teacher

MACOMB INTERMEDIATE SCHOOL DISTRICT
AUXILIARY SERVICE CENTER
12225 MASONIC BLVD.
WARREN, MICHIGAN 48093
(313)268-3450

PHYSICAL THERAPY YEAR END SUMMARY

EXAMINER:	Judith L. Wagner	EXAM DATE:	June 1989
STUDENT:	CYNTHIA MYRONIUK	BIRTHDAY:	2/9/78
PARENTS:	John/Roxann	DISTRICT:	Utica
ADDRESS:	44084 Davis	SCHOOL:	Burr El.
CITY:	Utica 48087	GRADE:	
PHONE:	739-1929	I.E.P.C.:	4/20/89

DIAGNOSIS: Cerebral Palsy, Spastic Diplegia

****

Cindy has been seen by mobile physical therapy service on a once weekly basis for 25-30 minute sessions during the 1988-89 school year. The emphasis of therapy has been on increasing lower extremity range of motion, facilitating isolated movements in the lower extremities and improving ambulatory mobility, balance and gross motor skills. Cindy continues to be cooperative and performs directed activities to the best of her ability.

Cindy underwent a phenol block of the medial hamstrings and gastrocnemius muscles on April 11, 1989. Cindy is receiving additional outpatient physical therapy services via a private therapist on a three times per week basis per Dr. Edward Hurvitz's orders.

Range of Motion and Muscle Tone

Good improvements were noted in passive range of motion measured at the point of resistance felt including:

	Right	Left
Hip flexion	120 degrees	120 degrees
external rotation	30 degrees	30 degrees
straight leg raise	80 degrees	75 degrees
extension	WFL	WFL
Ankle dorsiflexion	5 degrees	8 degrees

Cindy can now bring her pelvis to 75 degrees from the floor in a long sitting position and can hold this position for 60 seconds.

Following the phenol block in April, increased bilateral lower extremity tone was noted to be less.

Strength and Isolated Movement

Some improvements in strength and isolated movements in the lower extremities were also noted. Consideration must be given to the strength grades being influenced by increased extensor tone.

	Right	Left
Hip flexion	fair +/good -	fair +/good -
abduction	fair +	fair +
Knee flexion	good -	good -
extension-a range of	fair - to good	
-a range of		fair - to good
Ankle dorsiflexion	fair -	fair -

Cindy is able to hold supine flexion for 15 seconds and prone extension for 16 seconds.

Ambulatory Mobility

The following gait observations were made after the phenol block.

A right pelvic drop during stance phase on the left, left hip internal rotation, right knee maintains some flexion most of the time during gait, right foot in a toe out position and left foot in a toe in position with bilateral foot drop. Less toe walking noted with heels closer to floor.

Reciprocal arm movement is present with upper extremities flexed at elbows in a mid-guard position. Cindy uses the wall for minimal support at times when walking down the hall and she traverses side to side somewhat during forward travel.

Cindy can now jump on both feet six times consecutively. She is able to walk sideways and backwards with better control. She negotiates stairs marking time, ascending and descending with one arm support.

Balance

Cindy's single leg stance time has increased to three to five seconds. She is able to maintain a squat position for 16 seconds. Cindy can maintain a half kneeling position for 17 seconds and is able to extend her opposite arm and leg in four-point for five seconds. Cindy is able to take two or three steps at a time accurately when walking on a one inch wide line. She continues to be able to walk sitting on haunches for short distances.

Assessment

Cindy has shown good improvements in range of motion, ambulatory mobility and balace skills during the 1988-89 school year.

Plan

It is recommended that Cindy continue to receive mobile physical therapy on a once weekly basis for session durations of 25-30 minutes for the 1989-90 school year. Cindy is to continue to receive outpatient therapy on a private basis during the summer per her parents. A list of suggested home exercises has been sent to Cindy's parents for any future use. Suggested goals for next year are as follows:

Annual Goals

I. Increase/maintain lower extremity range of motion.

II. Improve ambulatory mobility skills.

III. Improve balance and proximal stability.

IV. Improve gross motor skills

V. Facilitate isolated movements and normalization of tone.

Teri H. Cory

MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES
LIFE CONSULTATION CENTER
21885 DUNHAM ROAD (Area #1)
MT. CLEMENS, MICHIGAN 48043
469-5950

Agencies contacted trying to receive assistance enclosed.

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June 16, 1989

Mr. J. Myroniuk
44084 Davis
Utica, Mi. 48087

Dear Mr. Myroniuk:

This letter is to confirm your appointment at Life Consultation for CYNTHIA MYRONIUK, Tuesday, June 20, 1989, at 3:00 P.M.

It is necessary that the person applying for services be present at this appointment. Also, please bring the following with you:

Social Security Card

Medicare/Medicaid/other medical insurance card

(If insurance is HMO, i.e., Health Alliance, Blue Care Network, etc., please bring a referral with you to this appointment)

Documentation of Financial Income (Pay Stub, W-2 Form or copy of 1040 income tax)

PLEASE NOTE: If person applying for services in UNDER AGE 18, financial information pertaining to parents is required.

If person applying for services is OVER AGE 18, financial information pertaining to him/her is required, i.e., SSI, SSB, etc.

Please complete the attached forms with information regarding prospective client and bring them with you to your appointment. If you have any questions, please contact me at the above number.

Sincerely,

Teri Hibbard, M.A., L.L.P.,
Outpatient Supervisor

739-1929
963-6608 5-1:30 PM

cc: Ron Mortier, M.S.W., C.S.W.,
Intake Coordinator

Currently, receiving counseling for spouse and future counseling promised for family. Awaiting some financial assistance or guidance and assisted with Crippled Childrens for an equitable new contract.

Social Security Administration
Supplemental Security Income
Information

Office Address: 13780 E 14 Mi Rd
Warren, MI 48093

Telephone Number: 1-800-234-5774

John N. Myroniuk for
Cynthia Myroniuk
44084 Davis
Utica, MI 48087

Date: June 5, 1989

On June 5, 1989, we discussed eligibility for payments from the supplemental security income program with you.

This letter is an informal decision on your eligibility for Supplemental Security Income only. This does not affect your entitlement to Social Security benefits or Medicare.

We believe that, according to your statements, you are not eligible to receive supplemental security income benefits at this time because:

- ☐ You are not age 65 and neither blind nor disabled.
- ☐ You are neither a U.S. citizen nor lawfully-admitted alien or alien residing in the U.S. under color of law.
- ☐ Your monthly income of about $ is too high for any payment in this State.
- ☐ Your personal/you and your spouse's resources of about $ are more than the allowable limit of $
- ☐ You were not interested in filing a claim.
- ☐ You have not signed and returned the application which was completed with you over the telephone. To become eligible for payment, a signed application must be received by a Social Security office.
- ☒ Other. Your parents income of about $3,200.00 is too high for any payment in this State.

If you want a formal decision about your eligibility for supplemental security income, or believe that our information is incorrect or incomplete, you should file an application. You may file an application at any time. However, the date of this inquiry may be used as your filing date only if you file by August 5, 1989. If you do not file by this date, you may lose payments because of the limitation on the retroactivity of formal applications for supplemental security income.

If you have any questions about this letter, please telephone or visit any Social Security office. If you call in person, please take this letter with you.

Form SSA-L991-U2 (8-88)
Use Until Stock is Exhausted

1st TIME

Pontiac
Marilyn Smith
1-373-0500

MACOMB COUNTY HEALTH DEPARTMENT
SOUTHEAST HEALTH CENTER
25401 HARPER
ST. CLAIR SHORES, MICHIGAN 48081

PERSONAL HEALTH SERVICES
AND
CLINIC SERVICES
759-9000

BLOOD PRESSURE PROGRAM
759-9010

DANIEL C. LAFFERTY
Health Officer

LELAND C. BROWN, M.D.
Medical Director

RE: Cynthia Myroniuk
D.O.B. 2-09-78

DATE: 3-13-89

Dear Parent/Guardian:

It has been determined that:

1. ______ Your child IS MEDICALLY ELIGIBLE for Children's Special Health Care Services. Please CALL the number below to schedule an appointment to complete an application. If we do not hear from you within two (2) weeks we will assume you are not interested in this service.

2. ______ Your child is NOT MEDICALLY ELIGIBLE at this time for Children's Special Health Care Services. We will be glad to review additional medical reports in the future.

3. ______ Your child is eligible for additional diagnostic examinations at______________ in ________ months. The results of the first exam did not confirm medical eligibility. KEEP THIS LETTER, take it with you as authorization for the return visit.

4. ______ The report received is not current enough to determine medical eligibility.

5. ______ Coverage cannot be established or renewed without a current medical report from a specialist.

6. X Please sign the enclosed Release of Information and return it in the envelope provided.

7. ______ Please call this office (phone number below) for further information.

8. ______ OTHER: ____

Sincerely,

Mary Green

Children's Special Health Care Services
759-9055

(26JUN89 Cathy Engl -)

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COPY DISTRIBUTION:
White — Regional Office
Canary — LHD
Pink — Client/Family

Michigan Department of Public Health
Division of Services to Crippled Children
Children's Special Health Care Services
Assessment for Services - Part II
Financial Assessment

Regional Office Use

1. CHILD/CLIENT(S) NAME: Myroniuk, Cynthia

2. EMPLOYMENT HISTORY:

	Wage Earner 1	Wage Earner 2
a. Name	John	Roxann
b. Employer	Dept. of the Army	Curis Big Boy
c. Years with this Employer	7 years	5 years
d. Last Year's Income (Per IRS 1040)	$22539.12	$8479.88

3. WAGES FROM EMPLOYMENT:

a. Year to Date Projection Method

	Wage Earner 1	Wage Earner 2
gross year to date total on check	$	$ 3822.99
# of weeks to date of check	÷	÷ 17
average amount per week	=	= 224.88
# of weeks to annualize	x 52	x 52
projected annual wages	= $	= $ 11693.76

1st + 15th

Every two wks on Thurs

b. Straight Projection Method

gross total of paychecks submitted	$ 2671.01	$
# of paychecks submitted	÷	÷
average amount per paycheck	=	=
# of paychecks per year	x 12	x
projected annual wages	= $ 32052.12	= $

SUB TOTAL WAGE $ 43745.88

4. OTHER INCOME:

	Self Employed (Schedule C)	Farmer (Schedule F)	Supplemental Income (Schedule E)
Net Profit/Loss	$	$	$
Depreciation	+	+	+
Annual Income	$	$	$

SUB TOTAL OTHER INCOME $

5. ADDITIONAL INCOME
Examples:

Social Security; SSI; alimony received; child support received; unemployment compensation; workmen's compensation; disability benefits; pension/retirement; military allotments; veteran's benefits; interest from assets.

Source	Annual Amount
Interest	43.00

SUBTOTAL ADDITIONAL INCOME $ 43.00

6. TOTAL INCOME (sum of numbers 3, 4, and 5) TOTAL INCOME $ 43786.88

7. ALLOWABLE DEDUCTIONS

a. Work Related Expenses	Work Expense $251.00 Uniforms 1235.00	$ 1486.00
b. Alimony/Child Support paid	960.00 + 1200.00	$
c. Child Care for working parents	$80 x 12 - $30 x 40	$ 2160.00
d. Health/Hospitalization Ins. Premium	$7.86 x 12 =	$ 94.32

SUBTOTAL DEDUCTIONS $ 3740.32

8. TOTAL FAMILY RESOURCES CONSIDERED FOR PAYMENT AGREEMENT $ 40048.56

9. CORRESPONDING PAYMENT AGREEMENT AMOUNT FOR FAMILY SIZE OF 4 IS $ 50.00

Completion is necessary for enrollment in CSHCS
P-[illegible]

Authority: Act 368, PA 1978

10. Explanation/Elaboration

11. Outcome:

a. ☒ Recommend approval of DSCC/CSHCS beginning 11-30-88 and ending 5-30-90
month-day-year month-day-year

1. ☐ Without a payment agreement for reason of:

☐ Medicaid ☐ Adoption ☐ Child's death ☐ Family income ☐ Court Ward ☐ Other

2. ☒ With a recommended payment agreement amount of $ 50.00 for this service period

I understand this information is confidential and will not be released to any other individual or organization without written consent. I understand that DSCC/CSHCS will only pay for medical expenses related to the covered condition, which insurance or other third party payment does not cover. I understand I may be expected to sign a payment agreement with the State of Michigan. The amount will be based on my financial information and is subject to final approval by the DSCC/CSHCS Regional Office. I have the right to appeal if I have reason to believe the decision is incorrect or unjust.

Signatures John N. Myronick Mary Green 5-30-89
Legally responsible person LBS Representative Date

b. ☐ Family declined recommendation. Reason:

Signatures
Legally responsible person LBS Representative Date

REGIONAL OFFICE USE ONLY

☐ Approve as recommended

☐ Amend approval dates to beginning ______ and ending ______
month-day-year month-day-year

☐ Amend payment agreement recommendation to:

- ☐ No payment agreement for this period of service.
- ☐ Payment agreement of ______

☐ Family declined services. Reason:

Regional Office Reviewer Date

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF PUBLIC HEALTH
3423 N. LOGAN
P.O. BOX 30195, LANSING, MICHIGAN 48909

Dear Myroniuk Family:

You have recently scheduled an appointment to enroll, or renew enrollment, in Children's Special Health Care Services (also known as the Division of Services to Crippled Children). As a part of the enrollment, you will meet with a nurse from your health department for a family assessment. The nurse will talk with you about your family's needs and work with you to plan ways to meet those needs.

As a parent of a child with special needs, I am excited about parents and local public health professionals working together to develop plans that will help not only the child but the other family members as well.

I urge you to take some time before your next appointment to think about the needs of your family. For example, would you like some suggestions on how to communicate with doctors? Do you need help developing a medication schedule? Would you like to know how to find out more about what schools can do for your child? These are some of the areas that may be discussed. It may be helpful for you to make a list of problems and questions and bring it with you. You also might make a list of any services or techniques that have worked well for your family in managing your particular situation to share with the nurse. You never know, you might have the information that some other family has been looking for.

Just a small amount of time can make a real difference in planning for the year to come.

Sincerely,

Beverly McConnell

Beverly McConnell, Director
Parent Participation Project
DSCC/Children's Special Health Care Services

PRINTED ON RECYCLED PAPER

MACOMB COUNTY HEALTH DEPARTMENT
SOUTHEAST HEALTH CENTER
25401 HARPER
ST. CLAIR SHORES, MICHIGAN 48081

PERSONAL HEALTH SERVICES
AND
CLINIC SERVICES
759-9000

BLOOD PRESSURE PROGRAM
759-9010

CRIPPLED CHILDREN PROGRAM
759-9055

DANIEL C. LAFFERTY
Health Officer

LELAND C. BROWN, M.D.
Medical Director

RE: Cynthia Myroniuk
D.O.B. 2-09-78

DATE: 4-13-89

Dear Parent/Guardian:

It has been determined that:

1. X Your child IS MEDICALLY ELIGIBLE for Children's Special Health Care Services. Please CALL the number below to schedule an appointment to complete an application. If we do not hear from you within two (2) weeks we will assume you are not interested in this service.

2. ______ Your child is NOT MEDICALLY ELIGIBLE at this time for Children's Special Health Care Services. We will be glad to review additional medical reports in the future.

3. ______ Your child is eligible for additional diagnostic examinations at______________ in _________ months. The results of the first exam did not confirm medical eligibility. KEEP THIS LETTER, take it with you as authorization for the return visit.

4. ______ The report received is not current enough to determine medical eligibility.

5. ______ Coverage cannot be established or renewed without a current medical report from a specialist.

6. ______ Please sign the enclosed Release of Information and return it in the envelope provided.

7. ______ Please call this office (phone number below) for further information.

8. ______ OTHER: ____
____

(2^{30} pm)
TUES May 30th

Sincerely,

Mary Green

~~Kathy Bogl, LBS Representative~~
Mary Green, LBS Representative

Children's Special Health Care Services
759-9055

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2ND TIME

MACOMB COUNTY HEALTH DEPARTMENT

SOUTHEAST HEALTH CENTER
25401 HARPER
ST. CLAIR SHORES, MICHIGAN 48081

PERSONAL HEALTH SERVICES
AND
CLINIC SERVICES
759-9000

BLOOD PRESSURE PROGRAM
759-9010

DANIEL C. LAFFERTY
Health Officer

LELAND C. BROWN, M.D.
Medical Director

4-17-89

RE: Cynthia Myroniuk

Dear Parent/Guardian:

This letter confirms your appointment with Children's Special Health Care Services at the Southeast Health Center on 5-30-89 at 2:30 p.m..

Please complete the enclosed Parent Questionnaire prior to your appointment. Please Print.

The information contained in this questionnaire, and any additional information in your child's casefile, is confidential and will only be available to the Local Health Department and Children's Special Health Care Services staff. It will not be released to any other individual or agency without your written consent.

When you come to the appointment, please bring:

- the completed questionnaire
- current paycheck stubs representing one month's earnings
- a copy of last year's federal income tax return, completed schedules and W2(s)
- Medicaid card
- listing of all additional income(i.e. social security, interest, unemployment) with verification where available.
- Health insurance card, EXCLUSIONS if insured by an HMO
- monthly payments for health/hospital insurance, child support, alimony, child care for working parent(s), work related expenses with verification where available.
- confirmation of adoption or legal guardianship if this applies.

Please allow two (2) hours for your appointment.

If you have any questions please contact our office at 759-9055.

Sincerely,

Mary Green

Kathy Bogl, LBS Representative
Mary Green, LBS Representative

Macomb County Board of Commissioners

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Walter Franchuk - District 14
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Anthony V. Marrocco - District 17
P. Sandra Maniaci - District 18
George F. Killeen - District 19
Harold E. Grove - District 20
Elizabeth M. Slinde - District 21
Donald G. Tarnowski - District 22
Elmer J. Kuss - District 23
Hubert J. VanderPutten - District 24
Patrick J. Johnson - District 25

STATE OF MICHIGAN

REPLY TO:
Division of Servic[illegible]
Pontiac Regional [illegible]
1895 N. Perry
Pontiac, Michigan [illegible]
Telephone (313) [illegible]

DEPARTMENT OF PUBLIC HEALTH

June 6, 1989

Mr. & Mrs. John Myroniuk
44054 Davis
Utica, MI 4806[illegible]

Re: Myroniuk, Cynthia

Dear Mr. & Mrs. Myroniuk:

A review of your application for Crippled Children Program has been completed and to enroll in program services, it is necessary for you to sign the enclosed Payment Agreement.

The following is an explanation of 1) the total amount of financial participation for the current period of coverage; 2) how much (if any), you have indicated that you will pay now; and 3) how much of the agreement will be incorporated into monthly payments.

Total Amount of Agreement:

X	$ [illegible] per month for 12 months of Crippled Children Coverage		$ 480.00
X	$ [illegible] for 4 months of backdated coverage		$ 160.00
		TOTAL	$ 640.00

Method of Payment:

X Enclosed payment of $160.00 (made payable to "State of Michigan") with the signed agreement.

____ $____ will be incorporated into your monthyly payments.

* If the initial payment noted above is not enclosed with the agreement, we will incorporate that amount into your monthly payments.

Please carefully review the Payment Agreement, noting the instructions at the bottom. If you choose to participate in the program. SIGN THE PAYMENT AGREEMENT AND RETURN THE TOP THREE COPIES TO THIS OFFICE IN THE SELF ADDRESSED ENVELOPE BY THE DUE DATE OF [illegible]-20-89.

If you have any questions concerning this matter, please contact this office.

* Payments would be $54.00/month for 11 months and $46.00 for 12th month.

Sincerely,

Donna Schneider
Office Administrator
Pontiac Regional Office

Enclosures
cc: Macomb Co. Health Dept.

Distribution
White — DSCC Regional Office
Yellow — DSCC Central Office
Pink — LHD
Goldenrod — Parents

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
Division of Services to Crippled Children

PAYMENT AGREEMENT

Name(s)	Recipient ID(s)	County
Myroniuk, Cynthia		Macomb

I hereby agree to pay the State of Michigan or its designated representative a total of $ 640.00 for 16 months of Crippled Children eligibility. Payment of this amount establishes my child(ren)'s coverage for Crippled Children Services for the above-named child(ren) from 01-30-89 to 05-29-90.

I understand that payment for the above amount will be made within a twelve month payment period. I will make payments according to the amounts and due dates on the coupons supplied by the Division of Services to Crippled Children Regional Office. I understand that I will not receive monthly statements or reminders, and that it is my responsibility to send each monthly payment by the due date. Failure to send minimum monthly payments may jeopardize my child(ren)'s eligibility.

In addition, I understand that if I sign and return this agreement to the Regional Office by the due date of 06-20-89, eligibility will begin 01-30-89. However, if the signed agreement is not received in the Regional Office by the above stated due date, my child(ren)'s eligibility will begin the date the agreement is received in the Regional Office and will extend for 12 months. In this case, the total agreement amount will be $ 480.00, and monthly payments will be made over the next 12 months.

If my income is reduced and I am unable to make my monthly payments, I will contact the Division of Services to Crippled Children Representative or Regional Office within 30 days of the change for an official review of my financial situation. I understand that failure to make payments is a breach of this agreement, and may jeopardize my child(ren)'s eligibility.

If the total amount of this agreement exceeds the Division of Services to Crippled Children's expenditures for services, the first $50 of the difference is nonrefundable, and is used to offset processing costs. Amounts above $50 will be refunded. I understand that a refund, if due, cannot be issued until at least 18 months after the above eligibility period has ended. The reason is that providers have at least 12 months from the date of service in which to submit a bill.

I also understand that my child(ren)'s coverage may not be renewed unless the obligations of this agreement are fulfilled.

(Signature of Parent or Guardian)

(Date of Signature)

Instructions to Parent or Guardian

1. Sign and date all four copies of this agreement. Keep the goldenrod copy for your own record. Mail the remaining three copies to the Division of Services to Crippled Children Regional Office in the enclosed, addressed envelope.
2. When you receive your book of coupons, send your first coupon with a check or money order payable to the "State of Michigan" by the due date indicated on the coupon. **Please note** the amount of the coupon before sending your payment; the last coupon in the book may be a different amount than the others. Mail all payments to the address printed on the coupons.
3. Continue sending a coupon and check or money order each month by the due date on each coupon until all payments have been made.

The DSCC Appeals Process available to all clients may be pursued for reconsideration.

P-787 7/86
Completion is necessary for
enrollment in DSCC Services

Authority Act 368, P.A. 1978

3RD TIME
w/ ASSISTANCE FAX!
LIFE CONSULTATION CENTER

STATE OF MICHIGAN

REPLY TO
Division of Services to Crippled Children
Pontiac Regional Office
1895 N. Perry
Pontiac, Michigan 48055
Telephone (313) 373-0500

DEPARTMENT OF PUBLIC HEALTH

July 3, 1989

Mr. & Mrs. John Myroniuk
44084 Davis
Utica, MI 48087

Re: Myroniuk, Cynthia

Dear Mr. & Mrs. Myroniuk:

A review of your application for Crippled Children Program has been completed and to enroll for program services, it is necessary for you to sign the enclosed Payment Agreement.

The following is an explanation of 1) the total amount of financial participation for the current period of coverage; 2) how much (if any) you have indicated that you will pay now; and 3) how much of the agreement will be incorporated into monthly payments.

Total Amount of Agreement:

X $ 40.00 per month for 12 months of Crippled Children Coverage $ 480.00
X $320.00 for 8 months of backdated coverage $ 320.00
TOTAL $ 800.00

Method of Payment:

X Enclosed payment of $320.00 (made payable to "State of Michigan") with the signed agreement.

___ $___ will be incorporated into your monthyly payments.

If the initial payment noted above is not enclosed with the agreement, we will incorporate that amount into your monthly payments.

Please carefully review the Payment Agreement, noting the instructions at the bottom. If you choose to participate in the program. SIGN THE PAYMENT AGREEMENT AND RETURN THE TOP THREE COPIES TO THIS OFFICE IN THE SELF ADDRESSED ENVELOPE BY THE DUE DATE OF 07-20-89.

If you have any questions concerning this matter, please contact this office.
Payments would be $67.00 for 11
months & $63.00 for 12th month.

Sincerely,

Donna Schneider
Office Administrator
Pontiac Regional Office

Enclosures
cc: Macomb Co. Health Dept.

PRINTED ON RECYCLED PAPER

Distribution:
White — DSCC Regional Office
Yellow — DSCC Central Office
Pink — LHD
Goldenrod — Parents

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
Division of Services to Crippled Children

PAYMENT AGREEMENT

Name(s)	Recipient ID(s)	County
Myroniuk, Cynthia		Macomb

I hereby agree to pay the State of Michigan or its designated representative a total of $ 800.00 for 20 months of Crippled Children eligibility. Payment of this amount establishes my child(ren)'s coverage for Crippled Children Services for the above-named child(ren) from 10-03-88 to 05-29-90.

I understand that payment for the above amount will be made within a twelve month payment period. I will make payments according to the amounts and due dates on the coupons supplied by the Division of Services to Crippled Children Regional Office. I understand that I will not receive monthly statements or reminders, and that it is my responsibility to send each monthly payment by the due date. Failure to send minimum monthly payments may jeopardize my child(ren)'s eligibility.

In addition, I understand that if I sign and return this agreement to the Regional Office by the due date of 07-20-89, eligibility will begin 10-03-88. However, if the signed agreement is not received in the Regional Office by the above stated due date, my child(ren)'s eligibility will begin the date the agreement is received in the Regional Office and will extend for 12 months. In this case, the total agreement amount will be $480.00, and monthly payments will be made over the next 12 months.

If my income is reduced and I am unable to make my monthly payments, I will contact the Division of Services to Crippled Children Representative or Regional Office within 30 days of the change for an official review of my financial situation. I understand that failure to make payments is a breach of this agreement, and may jeopardize my child(ren)'s eligibility.

If the total amount of this agreement exceeds the Division of Services to Crippled Children's expenditures for services, the first $50 of the difference is nonrefundable, and is used to offset processing costs. Amounts above $50 will be refunded. I understand that a refund, if due, cannot be issued until at least 18 months after the above eligibility period has ended. The reason is that providers have at least 12 months from the date of service in which to submit a bill.

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P-787 7/86
Completion is necessary for
enrollment in DSCC Services

Authority: Act 368, P.A. 1978

Page: 1

MACOMB PHYSICAL THERAPY & REHAB.
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

Fed Ident: 38-2441107
Pat Ident: MYR
Therapist: EDMUND TURTON, RPT
Physician: EDWARD HURVITZ, M.D.
Diagnosis: 437.8
BRAIN OR CEREBRAL DIPLEGIA

Current billing and history for post phenol-bloc procedure and rehabilitation.

CYNTHIA MYRONIUK
44084 DAVIS
UTICA, MI 48087

STATEMENT OF ACCOUNT
All Activity Through 05-30-1989

Date	Type	Description	Amount
4/14/89	97720	EVALUATION-30'	45.00
	97110	THERAPEUTIC EX-30'	20.00
4/17/89	97110	THERAPEUTIC EX-30'	40.00
4/19/89	97110	THERAPEUTIC EX-30'	40.00
4/21/89	97110	THERAPEUTIC EX-30'	40.00
4/24/89	97110	THERAPEUTIC EX-30'	40.00
4/26/89	97110	THERAPEUTIC EX-30'	40.00
4/28/89	97110	THERAPEUTIC EX-30'	40.00
5/01/89	97110	THERAPEUTIC EX-30'	40.00
5/03/89	97110	THERAPEUTIC EX-30'	20.00
5/05/89	97110	THERAPEUTIC EX-30'	40.00
5/08/89	97110	THERAPEUTIC EX-30'	40.00
5/10/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
5/12/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
5/15/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
5/17/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
5/22/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
5/24/89	97110	THERAPEUTIC EX-30'	20.00
	97110	THERAPEUTIC EX-30'	20.00
			$685.00

BIODEX EXERCISE STATISTICS REPORT

Patient 1009 on 06/21/89 at 16:33:37

Name :
Weight : 72
Age :
Sex :
Height :
Referral :

Serial # : 446
Calibration : 12/16/88 at 11:33:14
Settings :
Injury/Surgery:
Involved Side :
Clinician :

EXERCISE MODE: Isokinetic at 270/270 deg/sec

EXERCISE 10 repetitions REST 30 seconds REPEAT 10 times

Period /Speed	Elapsed Time (secs)	Compliant Reps	Peak Torque (ft-lbs)	Peak 2 Torque (ft-lbs)	Time to Peak 1 (msec)	Time to Peak 2 (msec)	Work 1 Total (ft-lbs)	Work 2 Total (ft-lbs)	Max Rep Work 1 (ft-lbs)	Max Rep Work 2 (ft-lbs)	Work 1 /Body Wt (%)	Work 2 /Body Wt (%)
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

UNIVERSITY OF MICHIGAN HOSPITALS
PHYSICAL MEDICINE AND REHABILITATION
PRESCRIPTION FORM

[illegible] F

Location Date 5.00 Service

CN°GATES
Reg. No. 2 09 78 UTICA Class
MYRONIUK, CYNTHIA MARIE Name
2106 231 5 23
Address

DIAGNOSIS: Spastic Diplegia

SYMPTOMS AND PHYSICAL FINDINGS

AGE 11 ☐ MALE ☒ FEMALE

STAFF M.D. HURVITZ

RESIDENT M.D. ____

____ WEEKS

____ DATE

____ PRN ONLY

Priority:
☐ Urgent
☐ I
☐ II

Location:
☐ [illegible]
☐ University Hospital

Edward Hurvitz
PHYSICIANS SIGNATURE

DATE ORDERED	TREATMENT	TIME	SPECIFICATIONS	DATE DISC.
5/4/94	PT	7W	Stretching espec Hamstrings & Adductors Gait training. Avoid toe walking Normalize pattern Good for 3 mos	

(FLIP UP AND OVER)

UNIVERSITY OF MICHIGAN HOSPITALS
PHYSICAL MEDICINE AND REHABILITATION
PRESCRIPTION FORM

Location Date Service

CH8GATES

Reg. No T 2 09 78 UTICA Class

MYRONIUK, CYNTHIA MARIE Name

2106 231 5 23

Address

DIAGNOSIS: Spastic Diplegia

SYMPTOMS AND PHYSICAL FINDINGS

Edward Hurvitz
PHYSICIANS SIGNATURE

AGE 11 ☐ MALE ☒ FEMALE

STAFF M.D. Edward Hurvitz
Hurvitz

RESIDENT M.D. ____________

____________ WEEKS

____________ DATE

____________ PRN ONLY

DATE ORDERED	TREATMENT	TIME	SPECIFICATIONS	DATE DISC.
4/5/89	PT	TIW	Stretching Gastrocs & Hamstrings Gait Training - emphasize proper pattern	

(FLIP UP AND OVER)

PLAN OF CARE

PATIENT: CYNTHIA MYRONIK

DIAGNOSIS: Spastic Diplegia

PROBLEMS:

1) Restricted motion at hip and ankle.
2) Muscular weakness at both lower extremities.
3) Ataxic gait pattern.

GOALS:
☒ INCREASE ROM
☒ INCREASE STRENGTH
☐ IMPROVE FUNCTION
☐ INCREASE UNDERSTANDING
✓INDEPENDENT AMBULATION
☐ INCREASE MOBILITY
☐ INCREASE GENERAL FITNESS
☐ DECREASE PAIN
☐ DECREASE EDEMA

TREATMENT:

1) Exercises to both lower extremities.
2) Stretching and strengthening exercises.
3) Gait training with proper patterning.

FREQUENCY: 3 x's weekly

DURATION: 4 weeks.

☑ RECHECK WITH PHYSICIAN AT END OF SERIES

☐ RECHECK WITH PHYSICIAN ON ______________

04-14-89
EDMUND TURTON, RPT
(313)286-8280
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

~~JOHN HURLEY, M.D.~~
EDWARD HURVITZ, M.D.

RC 4-24

INITIAL/RE-EVALUATION

NAME: CYNTHIA MYRONIK   CLINICAL DIAGNOSIS:

PHYSICIAN: ~~JOHN HURLEY, M.D.~~ EDWARD HURVITZ, M.D.

04-14-89

S. Patient seen for the first time today. Father acted as historian and noted that she had a phenol block performed on April 6, 1989. Patient offers no complaint of pain and discomfort, only when she does her exercises.

O. AMBULATION Patient ambulates with spastic gait, with the left lower extremity internally rotated.

ROM Passive range of motion within normal limits except for restricte motion upon internal rotation, 0 on the right, normal on the left. External rotation normal on the right, 10° on the left. At the ankle, dorsaflexion 0 on the right, 5° on the left, plantar flexion normal bilaterally. Active motion is restricted by muscular weakness and is limited upon straight leg raising, abduction and also extension.

MS Flexion bilaterally is fair-, extension fair-, abduction on the right is poor, on the left fair. Adduction poor on the right, fair on the left. Rotation bilaterally, poor, at the knees, flexion good- bilaterally, extension is fair bilaterally. Dorsiflexion is poor- bilaterally, plantar flexion good- bilaterally.

EXERCISES Patient is instructed in a home program of stretching exercises and gait training. She is highly motivated and anxious to do well.

EDMUND TURTON, RPT
(313) 286-8280
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

RC 4-24

PROGRESS NOTE/[illegible]

DATE: MAY 5, 1989

NAME: CYNTHIA MYRONIUK

PHYSICIAN: EDWARD HURVITZ, M.D.

CLINICAL DIAGNOSIS:

TREATMENT BEGAN: 05-0[illegible]-89

NO. OF VISITS:

IMPROVEMENT:
☐ EXCELLENT
☐ GOOD
☐ MODERATE
☐ MINIMAL
☐ NO CHANGE

COMMENTS AND RECOMMENDATIONS:

S. Patient saw her physician at U of M Hospital yesterday. Physician wants us to continue with treatment program. Patient notes that she has been following through with her exercises. She indicated that her new shoes are helping a great deal. She feels more secure with them.

O. ROM Right hamstring particularly seems to be tight. Adductors are easily stretched at this time, however, the right Achilles Tendon requires stretching.

TREATMENT:

PLAN:
☒ TREATMENT ONGOING
☐ DISCHARGED FROM PHYSICAL THERAPY
☐ PRESCRIPTION HAS EXPIRED, PLEASE ADVISE

EDMUND TURTON, RPT
(313)286-8280
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

PROGRESS NOTE/XXXXXXXXX XXXXXXX

DATE: APRIL 26, 1989

NAME: CYNTHIA MYRONIUK

PHYSICIAN: EDWARD HURVITZ, M.D.

CLINICAL DIAGNOSIS:

TREATMENT BEGAN: 05-03-89

NO. OF VISITS: 6

IMPROVEMENT:
[ ] EXCELLENT
[X] GOOD
[X] MODERATE
[ ] MINIMAL
[ ] NO CHANGE

COMMENTS AND RECOMMENDATIONS:

S. Patient is showing improvement. Stretching of hamstrings is getting much easier. Straight leg raising left @ 90°, right @ 75°, however after sustained stretch patient is able to maintain flexibility of the right lower extremity.

EXERCISES Patient has been put on an exercise program which consists of stretching to both hamstrings and right heel cord, and strengthening exercises to increase muscle strength at hip flexors, quadraceps and hamstring group.

AMBULATION Patient is ambulating without any assistive devices. Upon command she is able to ambulate short distances before she reverts to her spastic gait.

TREATMENT:

PLAN:
[X] TREATMENT ONGOING
[ ] DISCHARGED FROM PHYSICAL THERAPY
[ ] PRESCRIPTION HAS EXPIRED, PLEASE ADVISE

EDMUND TURTON, RPT
(313)286-8280
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

PROGRESS NOTE/DISCHARGE SUMMARY

DATE: MAY 15, 1989

NAME: CYNTHIA MYRONIUK

PHYSICIAN: EDWARD HURVITZ, M.D.

CLINICAL DIAGNOSIS:

TREATMENT BEGAN: 05-0[illegible]-89

NO. OF VISITS: 14

IMPROVEMENT:
[ ] EXCELLENT
[ ] MODERATE
[ ] NO CHANGE
[x] GOOD
[ ] MINIMAL

COMMENTS AND RECOMMENDATIONS:

S. Patient notes that she is doing her exercises. She points out that she has been walking around with cuff weights on her ankles.

O. ROM Passive range of hip motion is improved. Straight leg raising, passively, 90° on the right, 80° on the left.

HIP MOTION External rotation and abduction requires stretching in order to maintain flexibility.

AMBULATION Patient's ambulation has improved, but she still requires verbal encouragement to maintain her gait pattern.

TREATMENT:

PLAN:
[x] TREATMENT ONGOING
[ ] DISCHARGED FROM PHYSICAL THERAPY
[ ] PRESCRIPTION HAS EXPIRED, PLEASE ADVISE

EDMUND TURTON, RPT
(313)286-8280
43421 GARFIELD SUITE 6
MT. CLEMENS, MI 48044

STATEMENT

FROM

PED. OTORHINOLARYNGOLOGY ASSOC

DATE 6/30/89

JOHN N MYRONIUK
44084 DAVIS
UTICA MI 48087

FED ID NO.	TELEPHONE
382447054	313-357-2060
	$ ______ AMOUNT PAID
ACCOUNT NUMBER	
872-21022114	$ 50.00 AMOUNT DUE

PLEASE RETURN UPPER PORTION WITH YOUR PAYMENT AND IDENTIFY CHECK WITH YOUR ACCOUNT NUMBER. RETAIN THIS PORTION FOR YOUR RECORDS.

DATE OF SERVICE	#	PROC	DESCRIPTION	DX – CD	DR	PATIENT NAME	AMOUNT
6/30/89	[illegible]	90060	OFFICE VISIT, INTERMED, ESTAB		31	CYNTHIA	50.00

ENT = NO LONGER ACCEPTS CHAMPUS, WHEN HAVING ONE INSURANCE CARRIER, BECAUSE BILLING PAYMENTS AND PROCEDURES.

PERTAINS TO BIRTH DEFECT IN HEARING AND POST OPERATIVE FOLLOW-UP. AS WELL AS, CONTINUED OBSERVATION AND CARE.

ALICIA C SANDOVAL, M.D.,P.C.
43391 COMMONS DRIVE
MT. CLEMENS, MI 48044
Tele: (313) 263-0970
Employer ID: 382107399

06-29-89

Diagnosis	Diagnosis Code
WELL CHILD	V202

Date	Services rendered	Place of service	Code	Amount
06-27-89	CBC	ALICIA C SANDOVAL, M	85024	15.00
06-27-89	LAB.- TB TEST	ALICIA C SANDOVAL, M	86585	10.00
06-27-89	WELL CHILD 5-11 YRS SUBSE	ALICIA C SANDOVAL, M	90762	20.00

Due by	Prior Amt. Due	Total Charges	Tax Today	Paid Today	Total Due
Patient	0.00	45.00	0.00	0.00	45.00
Insurance	0.00	0.00	0.00	0.00	0.00
					45.00

Patient: CYNTHIA MYRONIUK
44084 DAVIS
UTICA, MI 48087

Signed: Alicia C Sandoval, M.D.

Date of next office visit is ___/___/___ at ______

PHYSICAL REQUIRED FOR MACOMB COUNTY HEALTH DEPARTMENT QUALIFICATIONS, NOT COVERED BY CHAMPUS AT ALL.

PEDIATRIC UROLOGY, P.C.

3901 BEAUBIEN BLVD.
DETROIT, MICHIGAN 48201
(313) 832-7051

DATE 06/17/89
ACCOUNT 14179

PAGE 1

CYNTHIA MYRONIUK
44084 DAVIS
UTICA, MI 48087

		=== INSURANCE ===		==== PRIVATE ====	
DATE	SERVICE	AMOUNT	BALANCE	AMOUNT	BALANCE
09/30/88	CYNTHIA (CLAUDE REITELMAN MD)				
	INITIAL OFFICE EXAM 09/26/88	60.00	60.00		
09/30/88	CYNTHIA (CLAUDE REITELMAN MD)				
	URETHROCYSTOGRAPHY 09/26/88	30.00	90.00		
11/12/88	CYNTHIA (CLAUDE REITELMAN MD)				
	URETHROCYSTOGRAPHY 11/04/88	30.00	120.00		
11/30/88	CYNTHIA (CLAUDE REITELMAN MD)				
	SUBSEQUENT EXAM 11/17/88	40.00	160.00		
11/30/88	CYNTHIA (CLAUDE REITELMAN MD)				
	URETHROCYSTOGRAPHY 11/17/88	30.00	190.00		
12/31/88	CYNTHIA (CLAUDE REITELMAN MD)				
	URETEROURETEROSTOMY 12/27/88	1475.00	1665.00		
02/11/89	CYNTHIA (CLAUDE REITELMAN MD)				
	POST OPERATIVE EXAM 02/06/89			N/C	0.00
02/11/89	CYNTHIA (CLAUDE REITELMAN MD)				
	URETHROCYSTOGRAPHY 02/06/89	30.00	1695.00		
03/31/89	INSURANCE PAYMENT - 1580163				
	URETEROURETEROSTOMY 12/27/88	1475.00CR	220.00		
03/31/89	INSURANCE PAYMENT - 1580162				
	INITIAL OFFICE EXAM 09/26/88	48.00CR	172.00		
	AMOUNT NOT COVERED BY INSURANCE				
	INITIAL OFFICE EXAM 09/26/88	12.00CR	160.00	12.00	12.00
03/31/89	INSURANCE PAYMENT - 1580162				
	URETHROCYSTOGRAPHY 09/26/88	24.00CR	136.00		
	AMOUNT NOT COVERED BY INSURANCE				
	URETHROCYSTOGRAPHY 09/26/88	6.00CR	130.00	6.00	18.00
03/31/89	INSURANCE PAYMENT - 1580161				
	URETHROCYSTOGRAPHY 11/17/88	24.00CR	106.00		
	AMOUNT NOT COVERED BY INSURANCE				
	URETHROCYSTOGRAPHY 11/17/88	6.00CR	100.00	6.00	24.00
03/31/89	INSURANCE PAYMENT - 1580161				
	SUBSEQUENT EXAM 11/17/88	24.80CR	75.20		
	AMOUNT NOT COVERED BY INSURANCE				
	SUBSEQUENT EXAM 11/17/88	6.20CR	69.00	6.20	30.20
	WRITTEN OFF				

CONTINUED ON PAGE 2

PEDIATRIC UROLOGY, P.C.

3901 BEAUBIEN BLVD.
DETROIT, MICHIGAN 48201
(313) 832-7051

CYNTHIA MYRONIUK
44084 DAVIS
UTICA, MI 48087

DATE 06/17/89
ACCOUNT 14179

PAGE 2

DATE	SERVICE	=== INSURANCE === AMOUNT	BALANCE	==== PRIVATE ==== AMOUNT	BALANCE
	CONTINUED FROM PAGE 1				
	SUBSEQUENT EXAM 11/17/88	9.00CR	60.00		
04/08/89	INSURANCE PAYMENT - 1588204 URETHROCYSTOGRAPHY 11/04/88	24.00CR	36.00		
	AMOUNT NOT COVERED BY INSURANCE URETHROCYSTOGRAPHY 11/04/88	6.00CR	30.00	6.00	36.20
04/15/89	CYNTHIA (CLAUDE REITELMAN MD) SUBSEQUENT EXAM 04/10/89	45.00	75.00		
05/31/89	INSURANCE PAYMENT - 1845659 SUBSEQUENT EXAM 04/10/89	24.80CR	50.20		
	AMOUNT NOT COVERED BY INSURANCE SUBSEQUENT EXAM 04/10/89	20.20CR	30.00	20.20	56.40
	CURRENT BALANCE		30.00		56.40

Re-constructive kidney surgery; birth defect.
Pre-op Exams
Follow-ups
Post-op Exams

Currently under further treatment for kidney & bladder disfunctions.

United States Senate
WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: NICK MYZIAK

Address 3140 HORTON, FARNDALE, MICH.
(313) 399-2863

Representing : NICK & ELIZABETH MYZIAK
BENEFIT PLANNING SERVICES, TROY

****

I invite you to attach a prepared statement or to submit your written testimony:

I AM AN INSURANCE AGENT IN THE BUSINESS OF SELLING HEALTH INSURANCE TO INDIVIDUALS AND BUSINESSES. I AM ALSO A DIABETIC (INSULIN DEPENDENT TYPE I). I have BEEN DIABETIC FOR 23 YEARS. BECAUSE OF MY DIABETES, I AM UNABLE TO OBTAIN HEALTH INSURANCE AT AFFORDABLE RATES, OR EVEN AT UNAFFORDABLE RATES. IT SEEMS THAT INSURANCE COMPANIES ONLY WANT TO INSURE THE HEALTHY AND people who pose A MINIMUM RISK. THATS BUSINESS AS USUAL, BUT BAD BUSINESS FOR THOSE WHO CAN NOT AFFORD TO MAINTAIN THEIR HEALTH. AS HEALTH INSURANCE RATES BECOME INCREASINGLY UNAFFORDABLE TO EMPLOYERS (AVG. RATE INCREASE 25-30% / YR.) more of our CITIZENS BECOME UNABLE TO OBTAIN COVERAGE. THERE ARE MANY AREAS THAT NEED TO BE ADDRESSED IN DEALING WITH THIS (OVER)

SITUATION.

1) HOSPITALS - These so called non-profit organizations charge ever increasing rates to Insurance companies and filter their profits into Buildings and equipment to use up profits. No regard is given to the cost of materials & supplies because they are simply past on to Insurance Co. & Individuals.

I would be very happy to further discuss this situation at greater detail. Thankyou for this opportunity.

Sincerely

(313)-3992863

TESTIMONY BY

WILLIAM FAIRGRIEVE

EXECUTIVE DIRECTOR

NATIONAL COUNCIL ON ALCOHOLISM, MICHIGAN DIVISION

The National Council on Alcoholism, Michigan Division appreciates the opportunity to testify on the "critical condition" of access to health care for the uninsured. We are the state affiliate of the National Council on Alcoholism which has approximately 200 affiliates across the Country, including twelve here in Michigan. Our organization is particularly concerned for those seeking help with alcohol and other drug problems without insurance coverage or the means to pay for such care on their own.

NCA/Michigan is a statewide voluntary organization seeking to increase awareness about the disease of alcoholism and other drug dependencies. To this end, we represent concerned citizens of the State of Michigan as an advocate to provide education, information and referral services to the general public, and to provide leadership in the formulation of policies related to the prevention and treatment of alcoholism.

As an advocate, NCA/Michigan analyzes issues and policies from the prospective of the chemically dependent person in need of services. In the course of talking with individuals experiencing alcohol and other drug problems, their families, treatment providers, and the payors of such care, both public and private, it is clear that there is a glaring gap in the availability of services for the indigent and the uninsured.

The motivation for alcoholics to seek treatment tends to be crises generated and of short duration. If a client must wait days, weeks, or even months to obtain care, many opportunities will be lost. Timing is everything in this field. When this complication is added to the other barriers to care, e.g. denial of services by many private treatment providers to persons without insurance, and the stigma associated with alcohol and drug problems - access is jeopardized for the estimated 360,000 alcoholics in Michigan.

The problems plaguing the substance abuse treatment system reflect those of the overall health care system - soaring costs, efforts by insurers to cut back on eligibility and benefits, and gatekeeper and reimbursement mechanisms designed to limit access to care. The end result unfortunately is a more costly and complex system that is increasingly difficult for the potential client to obtain access to care.

Alcoholism is one of the nation's major public health problems and it cannot be ignored. Recent studies indicate that the annual cost of alcoholism and alcohol abuse is over $130 billion in this Country.

Alcohol related problems are estimated to be directly responsible for a sizable portion of the nation's health care costs - about $15 billion annually.

Eighteen million American adults are either alcoholics or have alcohol abuse problems. An estimated 360,000 people in Michigan have alcoholism. 600,000 experience problems due to alcohol use. 24,000 Americans are killed and half a million people are injured in alcohol related motor vehicle crashes every year.

Long term alcohol consumption is linked to cancer, heart disease, cirrhosis of the liver and brain disease.

Some 40,000 babies are born each year at increased risk because of their mother's drinking during pregnancy. Fetal alcohol syndrome is one of the top three causes of birth defects and is the only one that is preventable.

We urge consideration of the following recommendations to bridge the gap in substance abuse care for the poor and uninsured:

1. Adopt changes in the federal regulations governing the Medicaid program to permit states to obtain federal match dollars for substance abuse services in non-hospital settings.

   Several years ago, Michigan participated in the Medicaid Alcoholism Demonstration Project permitting reimbursement of residential, detoxification, and outpatient substance abuse services. The results of the demonstration suggest it is a cost effective approach to providing access to care.

2. Fully fund the prevention and treatment provisions of the recently enacted Anti-Drug Abuse Act of 1988.

3. Assure that a continuum of alcohol and other drug dependency treatment services are provided through all programs designed to provide health care to the medically indigent and the uninsured.

Long term solutions to the uninsured problem will require developing a universal system of care which assures access to affordable quality care including substance abuse treatment to all United States residents. We urge you and other members of Congress to work toward this important goal.

Attached is a copy of the Report of the Michigan Chemical Dependency Policy Study Group published in 1987. It represents the thinking of NCA/Michigan and approximately 50 other organizations about substance abuse prevention, treatment, and reimbursement in Michigan. The report sheds further light on the issues we have raised in our testimony. We hope you will review its findings and recommendations as part of your deliberations on the critical problem of health care for the uninsured.

REPORT OF THE MICHIGAN CHEMICAL DEPENDENCY POLICY STUDY GROUP

June 1987

The Michigan Chemical Dependency Policy Study Group, formed in the fall of 1986, is a privately initiated and funded effort to examine and prepare a report about the state of chemical abuse and dependency and its treatment, prevention, and reimbursement in Michigan. The project was initiated by the Catherine McAuley Health Center, with the cooperation and support of the Michigan Coalition on Substance Abuse.

The 52 individuals serving on the study group represent prevention and treatment programs, insurers, businesses, state government, research, universities, private consulting firms, and community organizations. Our aim is to see reflected in Michigan's public policies the changes that have occurred in personal behavior, public opinion, and preventive educational/treatment methods since enactment of the Public Health Code in 1976.

The report was written for a broad audience: for policymakers, including the governor, members of the state legislature, state department and agency officials, and state advisory commissions and councils; for providers, purchasers and consumers of care for chemical abuse and dependency; for the media; and for residents of Michigan--all of whose lives are affected by substance abuse and dependency.

The six-month effort to research issues and form a consensus on recommendations has laid the groundwork for major changes in Michigan. The leadership of the study group recognizes the depth and breadth of this report's recommendations. We invite comments and reactions. We will work with public and private opinion leaders to help Michiganians understand the tremendous costs and human suffering engendered by abuse and misuse of and dependency on alcohol and other drugs; we will offer encouragement in stemming the epidemic of drug abuse; and we will monitor actions taken in private and public quarters to expand access to and enhance the quality of preventive and treatment services.

Neil J Carolan — Mary Morin

Neil Carolan
Chair

Mary Morin
Vice-chair

INTRODUCTION

Definitions

Chemical abuse[1] and dependency are major social problems, yet as traditionally defined, their widespread effect can be disguised. The following are customary definitions:

> Drug. Any chemical substance that produces physical, mental, emotional, or behavioral change in the user.
>
> Drug or substance abuse. Use of a substance to the extent that the resulting change becomes an impairment. Alcohol, tobacco, marijuana, heroin and other narcotics, sedatives, tranquilizers, cocaine and other stimulants, inhalants, and LSD and other hallucinogens are the drugs most often abused in our society.
>
> Chemical dependency. Psychological dependency is a condition in which substance abusers find it difficult to stop or control drug use because they feel they must have the drug to feel good or normal or just to get by. Physical dependency is a condition that occurs when a drug has so changed the user's body chemistry that the user will suffer physical withdrawal symptoms if he/she ceases use of the drug.

These definitions, while accurate, reflect society's tendency to limit consideration of substance abuse and dependency to their effects on the user alone. Many professionals working in prevention and treatment prefer broader definitions, defining substance abuse as "use that interferes with a person's family and social life, job, schooling, or health" and chemical dependency as "continued use of drugs after repeatedly experiencing their detrimental effects." Substance abuse and dependency, perhaps more than any other personal health problems, affect families, friends, co-workers, and employers of abusers. People who have close relationships with substance abusers are characterized as being codependent to emphasize their vulnerability to the tragic effects of substance abuse (which can include emotional trauma and domestic violence) even though they may not be abusers themselves.

In their larger social costs--crime, lost productivity, premature death, health care costs--substance abuse and dependency rival heart disease and cancer. Using the broader definition also acknowledges the immediate consequences of substance use: interference with one's life can be instantaneous. Abuse and dependency also cannot be defined by frequency or amount. There is no magic threshold that makes one an abuser or chemically dependent.

Most health professionals and laypersons now accept chemical dependency (including alcoholism) as a disease. There is no question that such a categorization has erased some of chemical dependency's moral stigma and encouraged the chemically dependent to see their problems as medically treatable.[2] Growing evidence that some people have a genetic susceptibility to alcoholism has helped as well.[3]

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[1] In this report, "chemical," "substance," and "drug" will be used interchangeably.

Resemblance to Other Diseases

In important ways, chemical dependency resembles other diseases. As medical science and technology chip away at disease and mortality rates, the role of personal behavior in determining one's health continues to increase. Many of our most prevalent diseases--heart disease, cancer, and lung disease as well as chemical dependency--are sometimes called "lifestyle" diseases because they can be caused, in part, by personal behavior and/or coping skills.

Approaches such as stress reduction and family counseling have long been essential in preventing and treating substance abuse and dependency; now they are integral to preventing and treating more "acceptable" diseases like cancer and heart disease. Substance abuse professionals believe that substance abuse and dependency must become part of the "health care mainstream"; that is, they should be treated and paid for just as are other major illnesses. Substance abuse and dependency are legitimate health problems and deserve to be given much greater attention and far more resources than at present.

Despite its important similarities to other diseases, chemical dependency is different. In all but the most severe cases, it does not show up on an X-ray or under a microscope. It is not treated with surgery. Chemical dependency evades easy categorization because it has psychological and social sources and manifestations that are impossible to measure. We are all familiar with many of the reasons people use or abuse drugs--to acquiesce to peer pressure, to relieve stress at home or at work, to repair low self-esteem, and to experience pleasure are just a few--but we know very little about the reasons behind the reasons. Why does one person succumb to peer pressure while another does not? Why does one person with low self-esteem turn to drugs while another does not? How does an individual's broad array of physiological, psychological, and social circumstances combine to result in abuse or nonabuse of drugs? No other disease has so many potential causes and so many different manifestations.

Prevalence and Costs

It is difficult to exaggerate the scope of America's problems with substance abuse and dependency. Illicit drug use in the United States probably exceeds that in any nation in the Western industrialized world.[4]

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[2] George Vaillant, as cited in Daniel Reeves, Barry Mintzes, and Robert Brook, Adolescent Alcohol and Drug Problems: The Need for a Continuum of Care (Lansing, Mich.: Michigan Office of Substance Abuse Services, December 1986), pp. 31-34.

[3] See, for example, R. Zucker and E. Gomberg, "Etiology of Alcoholism Reconsidered: The Case For a Biopsychosocial Process." American Psychologist 48 (1986), p. 7.

[4] Drug Abuse and Drug Research, the first in a series of biennial reports

(Footnote Continued)

Substance use and abuse cuts across socioeconomic strata. College students drink heavily more often than 18-to-20-year-olds who are not in college,[5] and college graduates drink more than those who have not gone to or graduated from college.[6] In a Wall Street Journal survey, 80 percent of surveyed American executives admitted to driving while drunk.[7]

National surveys indicate that by age 14, one-third of all young people have tried marijuana. Between 8 percent and 15 percent of high school seniors drink alcohol or smoke marijuana daily.[8] Thirty-seven percent of the people surveyed by the Michigan Department of Public Health (MDPH) admitted to drinking heavily (five or more drinks in a row) at least once in the previous month.[9] By age 27, nearly 40 percent of the population has tried cocaine.[10] As Lloyd Johnston concludes in his 1986 report for the National Institute on Drug Abuse (NIDA), Drug Use Among American High School Students, College Students, and Other Young Adults, "this nation's high school students and other young adults still show a level of involvement with illicit drugs which even by the historical standards in this country...remains extremely high."[11]

Despite the attention given in the media to crack and cocaine, the use of which is escalating despite growing public awareness of its dangers, alcohol is by far the most abused drug. An estimated 14 million Americans are alcoholics; 20 million more drink immoderately and are at risk of becoming alcoholics.[12] In Michigan, an estimated 750,000 residents currently need services for alcohol and other substance abuse problems. Of the 600,000 people in Michigan with alcohol problems, 360,000 of them are considered alcoholics. An estimated 150,000 Michigan residents misuse or abuse

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(Footnote Continued)
to Congress from the Secretary, Department of Health and Human Services (Rockville, Md.: National Institute on Drug Abuse, January 1984).

[5] Lloyd D. Johnston, Patrick M. O'Malley, Jerald G. Bachman, Drug Use Among American High School Students, College Students, and Other Young Adults: National Trends Through 1985 (Rockville, Md.: National Institute on Drug Abuse, 1986), p. 8.

[6] Alcohol Use and Abuse in America (Princeton, N.J.: The Gallup Report, November 1985), p. 12.

[7] Ibid., p. 3.

[8] Michigan Information Clearinghouse on Substance Abuse, Office of Substance Abuse Services, Michigan Department of Public Health, Lansing.

[9] Michigan's Health Status (Lansing, Mich.: Department of Public Health, Center for Health Promotion, January 1987), p. 3-27.

[10] Johnston et al., p. 8.

[11] Ibid.

[12] Alcohol Use and Abuse in America, p. 2.

prescription drugs. The number of heroin addicts in Michigan is estimated to be about 50,000.[13]

Alcohol abuse and alcoholism alone illustrate vividly the costs of drug abuse to users, to their families, and to society. The premature death rate for alcoholics is two and one-half times that of the rest of the population. More than 30,000 Americans die annually from cirrhosis of the liver, one of the many known physical ailments linked directly to alcoholism.[14] Over 12,000 cancer deaths during 1980 were related to alcohol abuse.[15] Alcohol use is implicated in approximately 65 percent of murders, 40 percent of assaults, 35 percent of rapes, and 30 percent of suicides. In addition, over 30 percent of fire deaths, 65 percent of drownings, 55 percent of arrests, and 50 percent of traffic fatalities involve the use of alcohol.[16]

The harmful consequences of alcohol abuse are not limited to adults. Alcohol-related trauma is the leading cause of death among those aged 1 to 19. One in 120 15-year-old males will die before his 25th birthday in an automobile accident. One to three of every 1,000 babies is born with fetal alcohol syndrome, the third leading cause of birth defects involving mental retardation in the United States and the only one of the three leading causes that is completely preventable.[17]

Substance abuse, of course, affects not only abusers but their families. One in five Americans says a drinking-related problem has caused trouble in his or her family.[18] Almost six million family violence cases each year are linked to alcohol abuse.[19] And perhaps most startling, 50 percent of alcoholics have an alcoholic parent.[20]

Drugs often take their toll in unsuspected ways. Of the 25 million elderly Americans (age 65 and over), as many as 90 percent are estimated to have suffered drug side effects--20 percent required hospitalization--due largely to the improper use of prescription and over-the-counter drugs.[21]

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[13] Michigan Information Clearinghouse on Substance Abuse.

[14] Ibid.

[15] "Alcohol Tax Policy Reform," American Journal of Public health 77 (January 1987): 107.

[16] Michigan Information Clearinghouse on Substance Abuse.

[17] "Alcohol Tax Policy Reform," p. 107.

[18] Alcohol Use and Abuse in America, p. 3.

[19] Rashi Fein, Alcohol in American: The Price We Pay (Newport Beach, Calif.: Care Institute, 1984), p. 18.

[20] Alcohol Use and Abuse in America, p. 9.

[21] Michigan Information Clearinghouse on Substance Abuse.

Conservatively, substance abuse problems are estimated to place a $3 billion annual burden on the Michigan economy due to absenteeism, health and welfare costs, and property damage. Lost productivity due to substance abuse costs Michigan business and industry more than $700 million annually. Twenty-five percent of the ambulatory care visits to health care facilities would be unnecessary if underlying substance abuse problems were not neglected.[22] Nationwide, an estimated 20 percent of hospital costs and 12 percent of total health care costs result directly from alcohol alone.[23]

Most Americans readily agree that alcohol and other drug abuse is a major health and social problem, yet we may not understand the many ways it enters our lives. Without realizing it, we have become the most self-medicated country in the world. We often condone alcohol and drug use, especially legal use, without a second thought. Drinking is widely accepted; many of us believe that liquor, beer, and wine are indispensable at social gatherings. Advertising tells us that we have ailments that only a pill or a drug can relieve.

A major reason for our acceptance of alcohol and other legal drugs is ignorance of their effects. Many people fail to see the potential dangers of drinking. A 1985 NIDA survey found that only 43 percent of high school seniors think that having five or more drinks once or twice each weekend can be harmful. Thirty percent of these same high school seniors see no great risk in consuming four or five drinks daily.[24] In a 1985 Gallup report, 30 percent of the adults surveyed disagreed with the statement "no one who drinks is immune from alcoholism."[25]

Prevention and Treatment

The goal of the National Institute on Drug Abuse is to eliminate substance use by (a) dissuading nonusers from experimenting with drugs and thus from progressing to their habitual use and (b) making the most effective treatment available to those who are substance abusers. The Office of Substance Abuse Services (OSAS) in the Michigan Department of Public Health has created a program to work toward these goals. Through 18 coordinating agencies, nearly 600 local programs, over 3,000 workers, and 20,000-30,000 volunteers, OSAS provides progressive prevention, casefinding, and treatment services. Substance abuse professionals believe that to achieve NIDA's goals, the general public's conventional ideas of substance abuse and dependency prevention and treatment must be expanded to take into account their physical, psychological, and social determinants.

Maintaining a stable life that discourages a return to drugs is a lifelong task, however hundreds of thousands of people have been able to accomplish it. Research and the experience of thousands of substance abuse workers are beginning to clarify how different services and treatments can help people improve or recover.

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[22] Ibid.

[23] "Alcohol Tax Policy Reform," p. 107.

[24] Michigan Information Clearinghouse on Substance Abuse.

[25] Alcohol Use and Abuse in America, p. 5.

Efforts to prevent chemical abuse and dependency must consider the psychological, social, and environmental circumstances of children and adults. Many people believe substance abuse prevention means teaching school children about the dangers of drugs and airing "Just Say No" public service announcements. While these are essential, preventing substance abuse involves a much broader range of strategies aimed at reducing the supply of and demand for alcohol and other drugs. Stricter law enforcement--more arrests and convictions of and longer sentences for drug dealers--and military efforts against cocaine producers in South America are attempts to limit the supply of drugs, as are the regulation of the sale and prices of alcohol and liquor taxes. Efforts to reduce the demand for substances extend from informing workers and children about the dangers of use and abuse to instilling in children and adults the self-esteem and social skills to resist drugs and alcohol.

Prevention and treatment efforts must also address the problems of codependency. Family members often need information about their special risks and counseling to help them repair emotional and physical damage (which can include neglect and violence) and understand that they are not at fault for the abuser's problem. Family counseling can also improve home life and enhance the support so crucial to the recovering family. Further, because studies show that children of alcoholics are more likely to marry or be an alcoholic, prevention and treatment services can be instrumental in stopping the passage of alcoholism into the next generation.

Funding and Reimbursement

During recent years, public expenditures for prevention and treatment have grown and private health insurance has been extended to cover treatment for substance abuse and dependency. For fiscal year 1986-87, the Office of Substance Abuse Services received over $38 million in state and federal funds, most of which were allocated to local prevention and treatment programs. Since 1981, Michigan law requires private third-party insurers to offer a minimum of $1,656 coverage (with subsequent adjustments for inflation) for substance abuse treatment in all group health insurance plans. Nevertheless, substance abuse and dependency prevention and treatment remain underfunded, especially if we consider their enormous human and economic costs, and third-party payers are more conditioned to pay for medical care than for the counseling, therapy, and support services substance that abusers need. State expenditures for chemical dependency programs in Michigan average $2.93 per capita; the national average is $3.04 (see Exhibit 1). Of the ten northern industrial states, Michigan ranks near the bottom in per capita state resources devoted to chemical dependency programs (see Exhibit 2).

The underfunding of substance abuse and dependency prevention and treatment falls hardest on the poor. Medicaid, which has limited coverage of substance abuse and dependency care, covers people who are aged, blind, disabled, or receiving Aid to Families with Dependent Children; this group, however, comprises only 31 percent of the poor. According to U.S. Census Bureau figures, 37 million Americans, the vast majority of them poor, have no health insurance. Over one million Michigan residents--11.4 percent of the population--have no health insurance. Without it, the poor in Michigan who need substance abuse and dependency care must seek it in state-funded programs, many of which have insufficient staff and funds to meet the need.

Because of health care cost-containment efforts, private programs sometimes refer clients whose insurance coverage has run out to public programs. This practice adds to the burden of state-funded programs. Greater resources must be devoted to ensuring that all residents of Michigan receive the substance abuse and dependency services they need, regardless of ability to pay.

In an age of limits, large increases in government spending for human service or other programs are simply not feasible politically. The answer to the problems of substance abuse and dependency is ultimately not only in the money we spend to combat them, but also in our attitudes toward them and in motivating healthier behavior. Our society must understand the ways substance abuse and dependency affect our lives and take greater responsibility for our individual and collective health. We must also assure that access to services does not necessarily depend on the financial status of the individual in need.

Diverting disproportionate substance abuse prevention and treatment monies to stricter law enforcement understates the complex nature of the illness and would undermine the efforts of substance abuse professionals to prove that substance abuse and dependency can, in many instances, be prevented and treated. While drug dealers must be apprehended and punished, stricter law enforcement is not a panacea; alcohol, a legal drug, is by far the most abused substance in our society and the majority of alcoholics, even while doing considerable harm to themselves and their families, do not break laws. Further, punishing, rather than treating, substance abusers usually only postpones their return to drugs, the need for which may be intensified by the trauma of arrest.

Substance abuse and dependency are major health problems, third only to heart disease and cancer in the number of people they affect.[26] They should be allocated the prevention and treatment resources commensurate with their gravity. The social and economic costs of alcoholism and other drug dependency are great; they are unfortunately perpetuated by social stigma and short-term and shortsighted reimbursement and funding policies.

The Statewide Study Group

To address chemical dependency issues and problems in Michigan, Catherine McAuley Health Center convened a statewide study group. This group, comprised of experts--providers, administrators, payers, advocates, regulators, and researchers--and others interested in chemical dependency, devoted six months to developing a comprehensive paper for the governor and legislature of Michigan recommending chemical dependency public policy changes.

The Michigan Chemical Dependency Policy Study Group stems from Catherine McAuley Health Center's growing involvement with services for the chemically dependent and its institutional mission to promote health care as a right rather than a privilege. Because of this, Catherine McAuley has become increasingly concerned about the complex and changing public attitudes and policies concerning chemical dependency prevention, treatment, and reimbursement.

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[26] Fein, pp. 34-35.

EXHIBIT I

PER CAPITA SPENDING FOR CHEMICAL DEPENDENCY PROGRAMS BY STATE

	State Expenditure (in thousands of dollars)	Per Capita[a] (in dollars)
Alabama	$ 1,855	$ .47
Alaska	14,001	28.00
Arizona	9,636	3.16
Arkansas	1,785	.76
California	75,954	2.96
Colorado	10,576	3.33
Connecticut	7,193	2.28
Delaware	2,445	3.99
D.C.	17,036	27.35
Florida	27,280	2.49
Georgia	19,093	3.27
Hawaii	1,340	1.29
Idaho	1,796	1.79
Illinois	39,794	3.46
Indiana	7,917	1.44
Iowa	8,624	2.96
Kansas	4,621	1.90
Kentucky	4,293	1.15
Louisiana	8,661	1.94
Maine	4,292	2.71
Maryland	21,802	5.01
Massachusetts	28,895	4.98
MICHIGAN	26,586	2.93
Minnesota	26,090	6.72
Mississippi	2,651	1.02
Missouri	6,978	1.39
Montana	2,146	2.60
Nebraska	3,941	2.45
Nevada	1,446	1.59
New Hampshire	1,030	1.05
New Jersey	12,205	1.62
New Mexico	10,474	7.35
New York	137,034	7.73
North Carolina	2,814	.47
North Dakota	1,017	1.48
Ohio	19,156	1.78
Oklahoma	4,055	1.23
Oregon	7,063	2.64
Pennsylvania	35,174	2.96
Rhode Island	5,399	5.61
South Carolina	4,008	1.22
South Dakota	855	1.21
Tennessee	4,934	1.05
Texas	5,820	.36
Utah	6,360	3.52
Vermont	2,159	4.07
Virginia	12,181	2.16
Washington	16,954	3.90
West Virginia	3,939	1.51
Wisconsin	44,277	9.29
Wyoming	2,940	5.75
TOTAL	$718,458	AVERAGE $3.04

SOURCE: William Butynski, State Resources and Services Related to Alcohol and Drug Abuse Problems: An Analysis of State Alcoholism and Drug Abuse Profile Data (Washington, D.C.: National Association of State Alcohol and Drug Abuse Directors, May 1986), p. 11.

EXHIBIT 2

STATE PER CAPITA EXPENDITURES FOR CHEMICAL DEPENDENCY PROGRAMS IN MICHIGAN AND OTHER NORTHERN INDUSTRIAL STATES (1984)

	Per Capita[a] State Support (in dollars)
Wisconsin	$9.29
New York	7.73
Minnesota	6.72
Massachusetts	4.98
Illinois	3.46
NATIONAL AVERAGE	3.04
Pennsylvania	2.96
Michigan	2.93
Ohio	1.78
New Jersey	1.62
Indiana	1.44

SOURCE: William Butynski, State Resources and Services Related to Alcohol and Drug Abuse Problems: An Analysis of State Alcoholism and Drug Abuse Profile Data (Washington, D.C.: National Association of State Alcohol and Drug Abuse Directors, May 1986), p. 11.

[a] Based on 1984 U.S. Census data estimates.

PREVENTION

Prevention of substance abuse and dependency has not received the attention it deserves. We have dealt with these problems by emphasizing the search for cures and giving too little attention to causes. Fully developed problems of abuse and dependency have an immediacy that easily claims our attention; the present costs of instituting prevention efforts are obvious, but the future costs of not doing so often go unrecognized.

While there has not been a strong constituency for prevention, there are indications of positive change. Citizen groups, such as Mothers Against Drunk Driving (MADD), and parent groups have had a highly visible influence on public policy; there are signs of a growing health consciousness in the general public; and federal and state lawmakers have begun to respond to increasing public concern about the country's drug problems. Yet awareness of what prevention means and how it can be accomplished is still limited.

Recent media coverage of the drug issue has focused on the exotic and the illicit--most notably, cocaine and crack. Yet, the most widespread, serious, and longstanding problems of abuse and dependence involve common legal substances--alcohol, tobacco, and prescription drugs. Among adults, especially women, prescription drugs are used more widely and with more serious consequences than are illegal drugs. Further, young people are frequently initiated into other prohibited drug use through alcohol and tobacco. Many experts believe that delaying or preventing teenage tobacco and alcohol use can significantly reduce the use of illegal drugs like marijuana and cocaine. For these reasons, Michigan prevention efforts should target alcohol, tobacco, and prescription drugs; illegal drugs, of course, also warrant serious attention.

Substance abuse and dependency prevention specialists make useful distinctions among primary, secondary, and tertiary prevention. Primary prevention efforts are intended to reduce experimentation with potentially dangerous substances; secondary prevention strategies attempt to prevent use from becoming abuse or dependency; and tertiary prevention efforts are aimed at limiting the health and social consequences of developed abuse and dependency problems. The study group's recommendations touch on all three types of prevention, although there is great emphasis on primary prevention--for example, in recommendations dealing with family- and school-based efforts intended for children and adolescents. Successful primary prevention, of course, reduces the need for secondary and tertiary prevention and contributes to alleviating the many health and social problems correlated with substance abuse and dependency: increased health care costs, highway fatalities and other serious accidents, premature death, suicide, divorce, family violence, loss of productivity, emotional problems among the children of abusers--the list is long.

Substance abuse and dependency prevention strategies also are often divided into efforts to control the supply of substances and efforts to control demand. Recent U.S. military operations against cocaine producers in South America are a familiar example of efforts to restrict the supply; the media campaign urging young people to "say no" to drugs is an example of efforts to reduce demand. There is also a wide variety of measures much less familiar to the general public. The complex of laws and regulations governing sale, pricing, and taxation of legal substances--from those that set legal ages for alcohol and tobacco purchase to those that govern the dispensing of prescription drugs--are as much a part of controlling supply as is enforcement of laws against importation, possession, and sale of illegal substances. Efforts to restrict demand include not only negative sanctions for illegal substance use and media campaigns emphasizing the dangers of substance use, but also positive measures. Examples are programs to train parents to raise self-confident and savvy children, health education in schools and workplaces, counseling for people at high risk of becoming involved in substance abuse and dependency, and efforts to limit promotion of alcohol and tobacco products. Prevention efforts must also address the special needs and concerns of cultural subgroups and subgroups at particularly high risk of becoming substance abusers.

Further, effective prevention efforts must target not only individuals, but also the environments that influence them. While individual understanding, self-esteem, and social skills are important in resisting social and psychological pressures to use and abuse substances, we must also do what is possible to diminish these pressures. This can be done, for example, through publicly funded programs that foster unglamorous public images of substance use and, on the supply side, make potentially dangerous substances less readily available. Public policy, as well as the individual, has a role to play in saying no to alcohol and other drugs.

1. Problem Statement: There is a need to make greater efforts to address (a) the effects of substance abuse and dependency problems on the families of abusers and dependent persons and (b) the vital role of the family in preventing such problems.

Discussion: Substance abuse and dependency affect not only abusers and dependent persons, but also those around them, especially their families. The children of people with alcohol and other drug problems bear a great burden; often they have serious emotional problems. Such problems--including low self-esteem and lack of self-confidence--help make these children particularly susceptible to substance abuse and dependency. As expert Claudia Black states, it is estimated that children from families in which others have substance abuse and dependency problems develop such problems at a rate two to four times that of the general population. For these reasons, people undergoing treatment for substance abuse and dependency should receive training in parenting as part of their treatment or aftercare, and their children should receive counseling; treatment practitioners need to have better training in the family dimension of drug problems.

Parenting training should also be part of broader prevention efforts. We know that poor parenting and malfunctioning families often contribute to the development of substance abuse and dependency. As a recent National Institute on Drug Abuse monograph by David Baumrind points out, competent, firm, and responsible parents are much more likely to raise self-confident children who do not turn to drugs than are parents who are either too permissive or too authoritarian. People can learn how to be good parents, but these skills are seldom taught in our society. Making training in parenting skills widely available--to both future and current parents and to both troubled and normal families--would greatly increase the stability and health of families in our state and provide parents with practical skills to help prevent the substance abuse and dependency that often arise in malfunctioning families. The OSAS currently funds parenting training for both troubled and normal families in several parts of the state, but the program should be expanded.

RECOMMENDATION 1A: The OSAS should require that all licensed substance abuse and dependency treatment programs demonstrate that there has been assessment of the need for services for the children of those in treatment and that referrals have been made when necessary.

RECOMMENDATION 1B: The OSAS should require that all licensed substance abuse and dependency treatment programs demonstrate that there has been assessment of the need for parenting training for their clients and that referrals have been made when necessary.

RECOMMENDATION 1C: The OSAS should revise its counseling credential training manuals to include more material on the family genesis of substance abuse and dependency and their effects on children.

RECOMMENDATION 1D: The legislature should provide the OSAS with funds to expand its support of programs that provide parenting training.

2. Problem Statement: There is a need to intensify prevention efforts in schools.

Discussion: Many Michigan schools have made considerable progress toward providing a comprehensive basic health curriculum, and instruction about substance abuse and dependency is getting more attention. All students need a basic health and substance abuse and dependency curriculum such as that provided by the Michigan Model for Comprehensive School Health Education. A comprehensive school-based prevention effort must also include several other components:

- Substance abuse and dependency education for all teachers, administrators, other professional staff, and parents. Until the adults who daily influence school children understand substance abuse and dependency and their effects on the developing child, their abilities to conduct prevention efforts will be limited.

- Parenting training. Parents should be made aware of the relationship of effective parenting to preventing substance abuse and dependency.

- Student assistance programs to provide individual support for K-12 students who are at high risk of developing substance abuse or dependency problems and to refer them to appropriate agencies outside the school. (Children who come from homes where others have substance abuse or dependency problems, or who face other particularly stressful circumstances, are at high risk of developing problems. They are overrepresented among truants, drop-outs, and young lawbreakers.)

- Life skills development training to help students develop the social skills to cope with pressures to use or abuse substances.

- Consistent, clear, and fair school policies about substance use and abuse, including constructive alternatives to suspension for infractions of school rules.

RECOMMENDATION 2: The State should support comprehensive school-based prevention models that include continued support for (a) the Michigan Model for Comprehensive School Health Education or comparable health curricula that include significant substance abuse and chemical dependency education, (b) training for teachers, administrators, other professional staff, and parents on how substance abuse and dependency affect the family and on how to intervene with school-aged children in trouble because of their own or a family member's substance use or abuse, (c) parenting training, (d) K-12 student assistance programs, (e) K-12 life skills development training, and (f) school policies on substance use and abuse that are consistent, clear, and fair, including alternatives to suspension for infractions of school rules.

3. Problem Statement: There is a need to ensure that professionals in education, legal and judicial, corrections, social welfare, and medical systems have basic knowledge of substance abuse and dependency, their effects on the family, and prevention methods.

Discussion: Many problems dealt with by professionals in many fields are related to substance abuse and dependency, yet few professionals are adequately trained to identify the problems and initiate appropriate remedial measures. For example, according to the 1985 Gallup report on alcohol use and abuse in America, the average physician in the United States has received no more than five hours of training in dealing with alcoholism despite the striking prevalence of alcohol-related health problems.

RECOMMENDATION 3: The OSAS should work with the relevant agencies and associations to develop a plan--including professional education requirements and provision for in-service training--to enable professionals in education, law and the judiciary, corrections, social welfare, and health and medicine to gain a basic knowledge of substance abuse and dependency, their effects, and methods of prevention.

4. Problem Statement: There is a need to encourage businesses to institute prevention programs in workplaces.

Discussion: The possibility of developing substance abuse and dependency does not end when people leave school and neither should prevention efforts. The state's business and industrial workplaces are logical locations for prevention efforts; not only because a large portion of Michigan's adults could be reached, but also because business and industry suffer substantial losses as a result of substance abuse and dependency. The OSAS estimates that problem drinking and alcoholism alone affect nearly 10 percent of the state's work force and that substance abuse and dependency cost Michigan business and industry more than $700 million a year. Employees, of course, have much to lose when such problems interfere with their performance on the job; this is a powerful motive to heed and participate in prevention programs. Comprehensive workplace programs would promote positive health habits, provide basic education on substance abuse and chemical dependency, encourage peer influence and support, and provide for intervention on behalf of employees at high risk of developing problems.

RECOMMENDATION 4A: The departments of Labor and Commerce should cooperate with the OSAS to develop a model workplace prevention and intervention program, adaptable to small as well as large businesses.

RECOMMENDATION 4B: The Michigan Insurance Bureau should work with the insurance industry to develop a plan to encourage health insurance companies to give significant rate reductions to employers who offer the state-approved model substance abuse and dependency prevention and intervention services to their employees.

5. Problem Statement: There is a need to ensure that prevention specialists meet minimum standards of skill and knowledge.

Discussion: Public and private businesses and other groups offering substance abuse treatment or rehabilitation services funded from public sources, patient fees, or third-party coverage must be licensed under Michigan Public Act 368 of 1978. The Michigan Credentialing Board--formed by the OSAS in cooperation with the Michigan Certification Board for Addiction Specialists, a private professional group--is developing standards for state certification of substance abuse treatment counselors. No public or private group, however, has established standards for certifying prevention specialists. While certification could not assure that all practitioners offer high-quality services, it would serve two purposes. It would assure that those who offer prevention services to the public--businesses, schools, and community groups--meet a minimum standard of skill and knowledge. Further, it would give health insurers a way to identify qualified prevention service providers, facilitating third-party coverage of these services.

RECOMMENDATION 5: The OSAS, in consultation with representatives of the substance abuse field and other appropriate groups, should develop criteria and procedures for certifying prevention specialists.

6. Problem Statement: There is a need to ensure that state policy does not encourage alcohol consumption or abuse.

Discussion: Low alcohol prices relative to other prices, high density of retail outlets, lax compliance with the law prohibiting sale to minors, and irresponsible serving practices in licensed establishments all encourage alcohol use and abuse. The question of alcohol prices is especially important. According to the OSAS, Michigan's beer tax has not been raised since 1966, the wine tax since 1937. Since both are per unit taxes (that is, a tax that is levied on the basis of volume rather than value), their value has been eroded considerably by the effects of inflation. The state has thus lost significant potential revenues, some of which could have been used to support substance abuse and dependency prevention efforts. And, since taxes are a major component of the retail price of alcohol products, artificially low alcohol tax rates have contributed to a decline in the relative retail price of alcohol products. Relative to inflation and to consumers' disposable incomes, alcohol prices have been dropping over the past three decades. The trend is important because, as a recent U.S. Department of Health and Human Services report notes that use of alcoholic beverages is price sensitive. In short, when prices relative to other beverages decline, people drink more. And when people drink more alcohol, the result is an increase in alcohol-related problems. Citing research findings that changes in the price of alcohol lead to changes in cirrhosis deaths, alcoholism levels, drunk driving, and teenage drinking, the same report concludes that "higher taxes on alcoholic beverages would decrease consumption and resulting alcohol-related problems." In 1986, the governing council of the American Public Health Association adopted a policy position calling for taxes on beer and wine equivalent to taxes on spirits (based on ethanol content) and for indexing taxes on all alcohol products to the inflation rate each year (for example, if the inflation rate rises by 3 percent, so would the tax per unit). Taking these steps in Michigan would

1. reduce levels of alcohol-related problems;
2. increase public revenues to support substance abuse programs and perhaps avoid the need for increases in other taxes; and
3. make the tax system fairer by assuring that heavy drinkers would pay a larger share of the costs resulting from their drinking.

The public at large favors an increase in alcohol taxes. A 1986 Gallup poll found that U.S. adults support increases by a better than two-to-one ratio (66 percent favor, 29 percent oppose). A 1984 Michigan survey conducted by Dr. Charles Atkin of Michigan State University yielded comparable results: two out of three adults support higher state taxes on alcohol.

Public policy should also address the density of retail alcohol outlets. A 1983 report prepared for the California State Health and Welfare Agency states that research over the past two decades suggests that "alcohol outlets play significant roles in the occurrence of health and social problems related to alcohol availability." A higher density of alcohol outlets has been linked, for example, to higher rates of cirrhosis of the liver and violent crime. Such cities as Los Angeles and Washington, D.C., have passed ordinances limiting retail alcohol outlet density. Michigan should study the use of such ordinances as a means of reducing alcohol-related problems, especially in urban areas.

Practices in establishments that serve alcoholic beverages affect availability at the point of sale. Although current law prohibits knowingly serving minors, establishments are often lax in inspecting patrons' identification. "Sting" operations in which law enforcement officers conduct unannounced inspections of bar patrons' identification are effective in encouraging more rigorous compliance with the law and limiting access by minors to alcohol.

Present law encourages licensed serving establishments to deny service to visibly intoxicated customers by holding the last licensed establishment to serve such a patron liable for injuries or death caused by the patron if intoxication is proved to be the proximate cause. In addition, licensed establishments should be encouraged to have their employees complete approved courses in responsible alcohol service--dealing with when and how to deny service, how to cope with intoxicated patrons, and related matters. Offering discounts on liability insurance would be an incentive.

RECOMMENDATION 6A: The legislature should raise beer and wine excise taxes to the level of taxes on spirits by making the tax per ounce of ethanol content the same, index excise taxes on all alcohol products to inflation, and ban price promotions of alcoholic beverages.

RECOMMENDATION 6B: The Michigan Liquor Control Commission should study the need for policies to limit the density of retail alcohol outlets, particularly in urban areas, and publicly report their findings within six months.

RECOMMENDATION 6C: State and local law enforcement agencies should vigorously enforce laws against serving and selling alcohol to minors.

RECOMMENDATION 6D: The Michigan Insurance Bureau should work with the insurance industry to develop a plan to offer significant liability insurance rate reductions to establishments licensed to serve alcoholic beverages whose employees complete approved courses in responsible service.

7. *Problem Statement*: There is a need to counter the influence of alcohol and tobacco industry advertising and promotion.

Discussion: Industry advertising presents alcohol and tobacco use not only as acceptable, but as essential to success and happiness. While cigarettes and cigarette advertising now bear warning labels, other tobacco products (such as pipe tobacco, cigars, snuff, and chewing tobacco) and alcohol--also potentially dangerous substances--are sold and advertised without acknowledgement or warning of their hazards; one such hazard is fetal damage from alcohol. Spokespersons for the alcohol, tobacco, and advertising industries often claim that advertising is intended and functions only to shuffle sales among different brands, not to increase demand. Even if this were the case--and much informed opinion contends that it is *not*--advertising not only fails to warn existing users of dangers, but also reinforces the propensity to use or to use in excess. According to one recent study, reported in the *Christian Science Monitor*, advertisements for alcohol products "appear to feed into the alibi system and the denial mechanism of alcoholics...." Advertising of both alcohol and tobacco products on college and university campuses is especially problematic since most undergraduate students are under the legal age for use of these substances.

Alcohol and tobacco advertising and promotion are ubiquitous in our society. Advertising encourages experimentation with these potentially dangerous substances and reinforces continued use, and it promotes attitudes inconsistent with the messages of substance abuse and dependency prevention.

RECOMMENDATION 7A: The legislature should appropriate funds for an ongoing advertising and public information campaign, to be overseen by the OSAS in cooperation with the MDPH Center for Health Promotion, to increase public awareness of the dangers of alcohol and tobacco use.

RECOMMENDATION 7B: The Liquor Control Commission should require that every establishment licensed to serve or sell alcoholic beverages post a standard notice warning of dangers to the fetus from drinking when pregnant.

RECOMMENDATION 7C: The legislature should ban alcohol industry promotional activities on campuses.

RECOMMENDATION 7D: The legislature should require alcoholic beverage and tobacco advertisers in college newspapers to fund counteradvertising, equal in space and cost to their product ads, on the dangers of alcohol and tobacco abuse.

RECOMMENDATION 7E: The legislature should ask the Michigan congressional delegation to introduce federal legislation requiring warning labels on all alcoholic beverages bottled or distributed in the United States.

8. Problem Statement: There is a need to control the abuse and diversion of prescription drugs.

Discussion: Prescription drugs are abused or misused by more Americans than cocaine, hallucinogens, or heroin. Prescription drugs are also identified in drug-related deaths and emergency medical situations more often than all illegal drugs combined.

Michigan is among the top states in per capita purchase and consumption of a variety of what are classified by the federal government as Schedule II prescription drugs. These drugs, which have currently accepted medical uses in the United States, have the highest potential for abuse or dependency among controlled medications.

A substance abuse problem is created by diversion of Schedule II drugs from legal and legitimate channels to illegal and abusive channels of distribution primarily through (a) forged and stolen prescription pads and forms; (b) illegal sale by dishonest pharmacies; (c) health practitioners who write prescriptions for profit; and (d) duped or out-of-date practitioners who inappropriately write prescriptions for abusing patients.

Currently, the printing of controlled substance prescription blanks is virtually unregulated. Anyone may legally print and possess prescription forms; only the use of forms to obtain a prescription fraudulently is illegal. Use of triplicate prescription forms (copies for the doctor, the pharmacist, and state government) and computerized tracking have been proposed. This would enable law enforcement officials to identify and investigate dishonest prescribers and dispensers efficiently and help identify (for education) out-of-date or gullible practitioners who are inappropriately prescribing Schedule II drugs.

Michigan also needs an accountable, interdisciplinary body with the responsibility and authority to deal with the prescription drug problem. The Board of Pharmacy, in the Department of Licensing and Regulation, administers licenses for prescribing and dispensing controlled substances for all health professionals. Other boards, such as the Board of Medicine, grant separate licenses to practice. Many health professionals feel it is difficult for the Board of Pharmacy to take strong action against professionals governed primarily by other boards. Further, no board has broad responsibility for developing and monitoring policies to deal with prescription drug diversion and abuse.

RECOMMENDATION 8A: The legislature should adopt a statewide triplicate prescription system for Schedule II drugs.

RECOMMENDATION 8B: A body, comprised of representatives of the various health profession regulatory boards in the Department of Licensing and Regulation should be formed to (a) administer and be accountable for controlled substances licensing and (b) develop and monitor policies to regulate the prescription and consumption of all controlled drugs.

9. Problem Statement: There is need to foster a consistent public attitude toward illegal substance use by enacting a statewide ban on the sale of paraphernalia for the use of illegal drugs.

Discussion: Paraphernalia for the use of illegal drugs--for example, water pipes for smoking marijuana and hashish, "roach" clips, "one-hitters," coke spoons, and pipes for smoking crack--are sold openly in stores throughout the state. Banning their sale would have no direct effect on the use of illegal substances because people can use makeshift equipment. However, permitting the open sale of such items contradicts the messages discouraging use of illegal substances that young people and adults receive from health, education, law enforcement, and other public institutions. Banning their sale would eliminate this inconsistency and help create an atmosphere in which use of illegal substances does not appear to be a normal part of everyday life. The City of Detroit and several metropolitan Detroit communities have enacted such a ban; without a wider ban, however, paraphernalia dealers merely move outside city or township limits. A wider ban would also create a supportive atmosphere for other statewide prevention efforts. The Michigan Senate passed a bill enacting a statewide ban in 1986 with almost no opposition, but the session ended before the bill could obtain a committee hearing in the House.

RECOMMENDATION 9: The legislature should enact a statewide ban on the sale of paraphernalia for the use of illegal drugs.

10. Problem Statement: There is a need to increase state funding for substance abuse and dependency prevention efforts, including research on the long-term effectiveness of prevention efforts.

Discussion: It is often easier and less costly to prevent a problem than to deal with it once developed. This is certainly true for substance abuse and dependency. As Dielman et al. point out in a discussion in the Journal of Pediatric Psychology on preventing adolescent alcohol misuse, "efforts to prevent detrimental health behaviors among children and adolescents are, if successful, more cost effective than are efforts at individual intervention subsequent to the development of a problem behavior."

Prevention efforts have long received less funding, from both private and public sources, than have treatment programs. Only about 15 percent of the 1985-86 OSAS budget was allocated to prevention. In some instances treatment does contribute to prevention, as when treatment of alcoholic parents includes parenting training and services for their children to help prevent alcohol abuse in the next generation. Generally, however, prevention has suffered relative neglect; better funding is necessary.

More funding is needed for research and evaluation. Since the aim of prevention is to influence behavior over many years, longitudinal research--that is, research that measures the effects of prevention efforts over long periods--is vital. All types of prevention efforts should be subject to research and evaluation, but since many substance use and dependency problems begin when people are very young, research on the effects of prevention programs for young people is especially important.

An agency such as the OSAS, or a coalition of relevant agencies, should be provided with a budget adequate to fund such research over an initial ten-year period. Agency scientists, with the assistance of consultants in prevention research, should develop and issue requests for research and evaluation proposals. Proposals should be subject to peer review by qualified scientists, and a scientific advisory committee should be formed to review research in progress and evaluate priorities for future research and evaluation funding. It is essential to sustain research and evaluation funding over several years. Expenditures on longitudinal research are worthwhile because the results permit resources to be used more efficiently.

Larger budgets for prevention should be funded from increased general fund appropriations and new sources of revenue. New revenue could be generated from higher taxes on legal substances subject to abuse. Cigarettes are the only tobacco products currently taxed; cigars, pipe tobacco, chewing tobacco, and snuff are not. Legislation imposing an excise tax on smokeless tobacco products (chewing tobacco and snuff) probably will be introduced this session. All alcoholic beverages are already taxed, but the taxes should be increased, particularly on beer and wine. A 1985 report issued by the OSAS, "An Analysis of Michigan Beer Prices and Revenues: Policy Opportunities and Their Impact on the Public," estimates that indexing beer taxes to inflation from 1967 through 1983 would have raised $77 million in additional revenue, and making beer taxes equivalent to spirits taxes (based on ethanol content) during that period would have produced $86 million in additional revenue.

RECOMMENDATION 10: The legislature should increase funding for substance abuse and dependency prevention efforts and research, especially longitudinal research and evaluation, from state general funds and new and higher taxes on tobacco and alcohol products.

OUTREACH, ASSESSMENT, AND REFERRAL

Our preconceived notions about substance abuse and dependency are attempts to distance ourselves from the problems and the people who have them: Substance abuse is a sign of moral weakness or lack of self-control; substance abusers are wash-outs or bums; and substance abuse cannot touch me or my family or my friends. It is not just substance abusers who deny their illness; family, friends, and associates cooperate by passing judgment or looking the other way.

Outreach must combat people's temptation to look the other way. Efforts to identify those in need of treatment and services must begin by educating everyone about substance abuse and chemical dependency, what may contribute to them, and how to recognize their symptoms. Everyone should understand that chemical dependency is a complex physical and psychological disease that does not discriminate--it affects people everywhere. The more we understand substance abuse and dependency, the more and the sooner we can help those in need seek treatment.

Before people begin treatment, their conditions must be assessed. As befits the complexity of substance abuse and dependency, this assessment must take into account a wide array of factors. In addition to measuring the problem's severity, a professional substance abuse assessor asks the client about possible family problems, education or job status, and other variables that may determine the kind, length, and intensity of treatment and services. Unfortunately, assessment (and thus referral) is not an exact science--it is often difficult for an assessor to (a) refer a client with certainty that he/she will receive appropriate care and (b) be certain what services every available treatment program provides. Moreover, in the intense competition among programs, some assessors may be motivated to refer clients into their own program although another program may be more suitable. The advent of uniform assessment tools and substance treatment case managers--client advocates who understand the system--promises to improve the likelihood that substance abusers will receive the most appropriate treatment possible.

11. Problem Statement: There is a need to identify those in need of chemical dependency care and related services and to improve their access to treatment.

Discussion: In Michigan, of the estimated 750,000 people currently needing services for alcohol and drug abuse, public and private programs treat approximately 100,000, or less than 20 percent. Insufficient numbers of programs in underserved areas help explain this service gap (see also Problem Statement 16), but the denial common among substance abusers probably accounts for the largest proportion of the gap.

Efforts to identify substance abusers and their codependents, alert them to available services, and help them receive assessments to determine their treatment needs are called casefinding. The OSAS licenses substance abuse and dependency programs for "casefinding-- organizational development." Programs licensed under this category customarily educate business, labor, and community organizations about substance abuse and dependency and help them develop strategies to identify and assist those in their families and organizations who need care. The number of programs so licensed has decreased in recent years. The OSAS should require all its coordinating agencies to increase organizational development, particularly for groups at high risk of becoming substance abusers.

One example of organizational casefinding is the employee assistance program (EAP), which has developed rapidly in recent years as a means to identify and help employees whose alcohol or other drug abuse affects their health and job performance. Statistics bear out the costs to business of employees who have substance abuse problems; James Francek notes in "Occupational Alcoholism Programs: Challenge and Opportunity" that those who abuse drugs have absenteeism and accident rates two to three times higher than those who do not. The mere existence of an EAP may be enough to encourage some substance abusing employees to seek help. Otherwise, a supervisor--who has been trained to recognize the effects of abuse and dependency on job performance--refers employees to the company EAP. The EAP staff assesses employees' needs and, if necessary, refers them to treatment programs. Despite evidence that EAPs reduce absenteeism and improve productivity by early identification and treatment of employees with substance abuse problems, most companies do not yet have EAPs. This is largely because most businesses in Michigan have fewer than fifty employees. For them, the cost of developing an EAP is prohibitive. To enable small businesses to offer EAPs, the Michigan State Chamber of Commerce and the Michigan Association of Small Businesses should meet regularly with representatives of local chambers of commerce and EAPs to develop programs for consortia of small businesses.

Another significant network of casefinding services owes its birth to Michigan Public Act 339 of 1983. This law requires screening and assessment of convicted drunk drivers to determine whether or not there is need for either education about or treatment for substance abuse problems. Probation officers are being trained in screening and assessment; where trained court personnel are not yet available, licensed substance abuse programs screen and assess the convicted drivers. Increasing numbers of individuals with alcohol and drug abuse problems are being identified and treated. Nevertheless, the law and the system have not been reviewed to determine how effectively they (a) identify and help substance abusers and the chemically dependent and (b) reduce repeated drunk-driving offenses.

Steps can be taken to reduce repeat drunk-driving offenses by high-risk drivers, many of whom are alcoholics. Studies show that only a small subset of alcoholics (5-20 percent) repeatedly commits traffic violations; although they still need treatment, other alcoholics, for whatever reason, are not dangerous drivers. To make its alcohol and highway safety program more effective, the State needs to identify this unsafe subset of alcoholic drivers and get them off the road. High-risk drivers can be identified from the Michigan Department of State driver file.

Outreach should focus on helping substance abusers receive treatment without violating confidentiality or their civil rights. Certain coercive casefinding methods--such as random drug testing in the workplace, placement by parents or guardians of a minor in substance abuse treatment without the minor's consent, and criminal prosecution of mothers whose babies die from fetal alcohol syndrome--threaten the civil rights of substance abusers and encourage punishment either before or instead of treatment. A broad-based body should be established to develop guidelines and standards for casefinding to ensure the preservation of confidentiality and the civil rights of the chemically dependent.

Many more substance abusers and dependents could be identified and encouraged to seek treatment if teachers, health professionals, and the intake staffs of state and local human service agencies had better knowledge of the symptoms of abuse and dependency and the resources in the community for treatment. Substance abuse and dependency bear heavily on other problems. For example, alcoholism and other drug abuse contribute to the conditions of 50 percent of the patients admitted to hospitals with other diagnoses, according to the American Hospital Association 1983 policy statement. Because clients and patients do not often admit to their or other family members' drug problems, it falls to the professional at hand to begin helping them. Training in identifying substance abuse and dependency should be required for teachers, health care professionals, and human service agency intake staffs. This should also include education in the perspectives and needs of special populations (adolescents, older adults, women, Blacks, Native Americans, Hispanics, and others).

Casefinding would be easier if substance abuse and treatment were not stigmatized. We often glamorize drinking, yet we consider it a weakness if we or a family member has a drinking problem. In a National Institute on Alcohol Abuse and Alcoholism study for the U.S. Congress, 45 percent of those surveyed believe that to assure privacy, treatment should be administered outside the client's neighborhood. Thus, it should not surprise us that even substance abusers who recognize that they need treatment may be reluctant to seek it for fear that they will be discovered and thought ill of. Efforts must be made to persuade the public that seeking substance abuse treatment is not the problem, but rather the way to end the problem.

Substance abusers who do want help do not always receive it. In addition to the dearth of programs in some areas (see also Problem Statement 16), many abusers and their families and friends are unaware of treatment programs in their communities. There is little information about what programs exist, the services they offer, whom they treat, and what they cost. (Financial barriers are discussed in the section of this report entitled "Reimbursement.") As many substance abusers seek treatment for only a short time before resorting to denial, the delays due to lack of information can be costly. To help remedy this, the OSAS, in consultation with the Michigan Coalition on Substance Abuse, the United Way of Michigan, and other agencies, should begin to develop (a) a statewide network of regional information centers to answer questions about substance abuse and dependency and (b) a 24-hour intervention line to provide those who want treatment immediately with information on available programs and their services and costs.

RECOMMENDATION 11A: The Michigan State Chamber of Commerce and the Michigan Association of Small Businesses should meet regularly with representatives of local chambers of commerce and employee assistance programs to develop employee assistance programs for consortia of small businesses.

RECOMMENDATION 11B: The OSAS and the Office of Highway Safety Planning should evaluate the effectiveness of the new drunk-driving laws in identifying and helping substance abusers. In addition, the Office of Highway Safety Planning, the OSAS, and the Michigan Department of State should collaborate to identify high-risk drivers from the Michigan driver file and develop strategies to reduce their involvement in traffic accidents.

RECOMMENDATION 11C: A broad-based body should be established to develop guidelines and standards for substance abuse and dependency casefinding to ensure the preservation of the civil rights of the chemically dependent.

RECOMMENDATION 11D: The OSAS should require all its coordinating agencies to increase efforts to help community organizations and businesses learn about substance abuse and dependency and develop strategies to identify and refer those who need treatment.

RECOMMENDATION 11E: The OSAS should offer grants to or contract with health care and social service professionals to develop training programs in substance abuse and dependency identification and referral.

RECOMMENDATION 11F: To help erase the stigma associated with substance abuse and dependency treatment, the OSAS, individual providers, and a major advertising agency should work together to develop public service announcements and pamphlets for statewide distribution that explain the benefits of treatment for substance abusers and for their families.

RECOMMENDATION 11G: The OSAS, in consultation with the Michigan Coalition on Substance Abuse, the United Way of Michigan, and other agencies, should begin developing (a) a statewide network of regional information centers to answer questions about substance abuse and dependency and (b) an intervention line--accessible 24 hours a day by toll-free number--to provide information on available programs and their services and costs to those who want treatment immediately.

12. Problem Statement: There is a need for professional substance abuse assessors to meet minimum standards of training and education.

Discussion: Substance abuse assessment requires more than reciting questions to a client. Assessors, like counselors, must know how to gain clients' trust so that they answer the questions about their substance abuse and their personal and social circumstances as truthfully as possible. The OSAS grants credentials to substance abuse counselors; assessors, who are vital in making certain that a client is properly referred for treatment, should receive specialized training and be required to meet minimum standards.

RECOMMENDATION 12: The OSAS and a state college or university should develop an instructional manual and skills test for substance abuse assessors. The OSAS should grant a credential to those who pass the test and require that all assessors be credentialed.

13. Problem Statement: There is a need for a series of uniform assessment tools, including tools especially tailored for specific groups such as adolescents, the elderly, and ethnic and minority populations.

Discussion: An understanding of clients' personal and cultural perspectives is essential to good assessment and treatment referral. For example, a specific assessment for older adults must take into account that they commonly take multiple drugs (alcohol as well as prescribed medications); that they are more vulnerable to health complications than younger adults; and that they are more likely to have diminished hearing or eyesight. Specific assessment tools are also needed for adolescents, women, and ethnic groups and minorities to assure that they receive treatment appropriate to their distinctive needs and perspectives.

Although assessment tools have been developed in many areas, their validation and dissemination have been slow because there is no means to test them and publicize the results. The development of uniform assessment tools could be expedited by an expert committee. Such a committee--comprised of assessment researchers, assessors, and clinicians--would identify, adapt, or develop uniform assessment tools for all populations and update them periodically in response to advances in research and treatment. Licensed programs should be required to use the appropriate assessment instruments as defined by the committee. Continuing education in administering these uniform tools would be required for the OSAS credential in assessment (see also Problem Statement 12).

RECOMMENDATION 13: The OSAS should establish an expert committee--comprised of assessment researchers, assessors, and clinicians--to identify, adapt, or develop uniform assessment tools.

14. Problem Statement: There is a need to improve the link between assessment and treatment referral so that the best interest of the client is served.

Discussion: It is often easier to characterize a complex problem than to treat it. Accurate assessments--those that correctly characterize a substance abuser's degree of dependency, willingness to recover, and personal and social resources available to sustain recovery--do not guarantee that a client will receive the most appropriate treatment. The reasons may be a lack of information on the comparative effectiveness of outpatient, residential, and inpatient care (see also Problem Statement 18) and/or unfamiliarity with program(s) having the particular services that match the client's needs. The OSAS requires for licensure that all programs in Michigan describe their treatment philosophy and range of services, but the OSAS Directory of Programs lists only the general levels of care (inpatient, outpatient, residential) for which a program is licensed. To better assist assessors in making appropriate referrals, more detail is needed on each program's treatment philosophy, range of services, and the specific populations served.

To increase further the likelihood that clients are referred into appropriate treatment settings, the OSAS should develop a client rating system to formalize levels of dependency. Although based on the detailed information gathered through uniform assessment, the levels need not be numerous: categories such as "mild" (receives outpatient care); "moderate" (receives residential care) and "severe" (receives inpatient care) would be sufficient. Such a system would also offer some safeguard against substance abuse service providers who assess and refer a client into their own program when the client would clearly be better off in a different setting. For example, with a client rating system, a program would have to show why a client with a "mild" rating needed other than outpatient care.

RECOMMENDATION 14A: To assist substance abuse assessors in making referrals, the OSAS should publish a detailed licensed program directory listing treatment philosophies, ranges of services, and the specific populations served.

RECOMMENDATION 14B: The OSAS should convene an expert committee to develop a client rating system to formalize clients' levels of dependency and improve the likelihood of referral into appropriate levels of treatment.

15. Problem Statement: There is a need for case management to ensure that each client receives the best possible substance abuse assessment, referral, and treatment.

Discussion: A substance abuser is sometimes at the mercy of the program at which he/she first appears for treatment. Programs may want to keep clients, regardless of the appropriateness of the treatments and services they offer. Problem Statement 14 addresses this issue from the perspective of assessment. Case management is a broader means of serving the client's best interests.

Ideally, the case manager would have training and experience in substance abuse counseling, but he/she would not be affiliated with a particular treatment program. Without such ties, a case manager would be free to help the client receive objective assessment, to ensure access to appropriate treatments and services, and to oversee the client's progress. The case manager can also see that a client on the verge of relapse reenters treatment before more intensive treatment becomes necessary. Because a case manager knows the substance abuse field better than a client, good case management may diminish the number of people who want treatment and do not get it.

Case managers can also help maximize public or private dollars by discouraging clients from going from program to program ("program shopping") to get immediate relief from the symptoms of their chemical dependency. Program shoppers avoid a long-term treatment plan that may help restore their health. By limiting unnecessary utilization of services, case managers benefit not only clients, but also state government and other payers for substance abuse treatment.

There are precedents for case management in state and local human services agencies and corporate employee assistance plans. Kent County, for example, has a "community case coordinating team" comprised of professionals from several human service agencies. The team meets regularly to review cases and determine the best and most efficient ways to deliver a range of human services that meets their clients' needs.

RECOMMENDATION 15: The OSAS should study case management plans in place in the public and private sectors to determine which can be best adapted to substance abuse services. Based on the study's findings, the OSAS should develop case management models for use by local substance abuse programs.

CONTINUUM OF CARE

In response to growing public concern about pervasive drug use and abuse in America, two solutions have attracted the most attention: prevention and punishment. While few question the need for widespread prevention and stricter law enforcement, the importance of treatment cannot be overlooked. Even if no one new were to become a substance abuser, millions would still need treatment. Michigan's present programs cannot provide enough treatment to meet the demand, let alone the need.

The Office of Substance Abuse Services licenses all substance abuse treatment programs in Michigan for inpatient, residential, and outpatient care. Inpatient care is medically supervised 24-hour-per-day treatment for persons in medical/surgical or psychiatric hospital beds. This may include acute detoxification (for patients whose alcohol or drug use has become life threatening) or subacute detoxification (for patients whose substance abuse is not life threatening). Including detoxification, inpatient programs usually hold clients for 28 days. Residential care is 24-hour-per-day treatment provided either in a freestanding facility (not physically attached to a hospital) or in a nonmedical/surgical hospital bed. Residential care can be divided into intermediate (usually 30-45 days), long-term/therapeutic community (usually 60 days or more), and long-term/halfway house (usually 6 months or more). Outpatient care is treatment in a nonresidential setting. The substance abuser does not live at the program facility and receives 1-5 hours of counseling a week. Some outpatient care is called day treatment or intensive outpatient care: substance abusers stay at the program facility during the day, but live at home.

Though the range and intensity of services vary from program to program, most inpatient, residential, and day treatment programs offer individual, group, and family counseling; structured work and recreational activities; and instruction, lectures, and films about substance abuse and dependency. Aside from day treatment, outpatient care usually concentrates on individual and family counseling.

As a part of treatment, every licensed substance abuse program is required to provide support and rehabilitation services for all clients. These services--education, vocational counseling and training, job placement, and financial, legal, spiritual, and nutrition counseling--can be offered by the program or by referral to other agencies. The Joint Commission on the Accreditation of Hospitals (JCAH) further requires all accredited programs to devise an aftercare plan of continued services for each client to help support and enhance the progress made in treatment.

The goal of treatment is not simply to eliminate dependence on alcohol or other drugs; it is also to develop self-esteem, proper management of stress, and access to family and social support that decrease the likelihood that a substance abuser will return to drugs. The whole person must be treated and continually treated. Recognition that most clients need a range of services over a long period has led to acceptance of the need for a continuum of care that allows clients to progress through increasingly less intensive treatments, repeating or bypassing levels of care as appropriate. Because relapse is frequent, a return to treatment, support services such as Alcoholics or Narcotics Anonymous, and aftercare are essential. Those who become chemically dependent are always recovering.

The frequency of relapse and the complex psychological and social factors that contribute to substance abuse and dependency make treatment--even more so than for most personal health problems--an inexact science. Though research has begun to address the comparative effectiveness of treatments and services in inpatient, residential, and outpatient settings, an absence of data makes it very difficult to determine which clients need which treatments and services and whether or not programs are doing the best they can to help clients progress.

Research and the experience of clinicians and counselors can alert us, however, to likely gaps in treatment. Existing programs cannot serve many of the poor who need treatment; large numbers of indigent and low-income substance abusers and dependents receive no care at all. Moreover, some substance abusers and dependents who do enter programs do not receive the care likely to benefit them most. Reimbursement policies--not the individual needs of the clients--often determine the kinds and duration of the treatments and services the chemically dependent receive. Too often, clients get what they can pay for, whether it is too little or too much. The poor, who often cannot pay, usually receive too little. Because reimbursement for health care inevitably lags behind advances in treatment, innovation is discouraged in this field, which already suffers from too narrow a range of services.

As better data and information on the comparative effectiveness of treatment become available, programs can be held increasingly responsible for the appropriateness and quality of the treatments and services they render. Traditional methods of quality assurance--licensing and accreditation of programs, credentialing of counselors--may give way to criteria based on sophisticated analysis of the outcomes of substance abusers' and dependents' treatment. Improved quality assurance measures can only benefit clients.

Chemical dependency is a complex disease. Though we do not know nearly enough about how to treat it, we do know enough to recognize that clients often need a wider array of services and longer periods of treatment than are presently available.

16. Problem Statement: There is a need to identify and narrow the gaps in the continuum of care.

Discussion: There are several reasons why six of seven substance abusers and dependents in Michigan go untreated. Denial, a common problem among alcohol and drug abusers, and lack of awareness about available services are two reasons. The section of this report entitled "Outreach, Assessment, and Refferal" discusses these two problems and offers recommendations to improve outreach. More treatment programs and services would also help diminish the large gap between substance abusers who seek treatment and those who receive it.

There has been a sizable increase in the number of programs in the state in recent years. Between fiscal years 1983 and 1986, the number of licensed substance abuse programs in Michigan increased 38 percent, from 419 to 580. Forty-three percent of these programs (250) accept some state funding and are thus required by state law to treat everyone, regardless of ability to pay, until their state funding runs out. When programs are full, those who cannot be accommodated immediately are placed on waiting lists.

As substance abuse and dependency treatment slowly gains acceptance among health insurers following the 1981 state law mandating its coverage, a larger percentage of new programs are choosing not to accept public funds and the attendant obligations to treat indigent and low-income substance abusers and their family members. Forty-three percent of the state's licensed programs accept public funding, but only 25 percent (13 of 52) of the new programs licensed in fiscal year 1985-86 do. Because state funding for indigent and low-income clients would not approach the money that programs receive for privately insured clients, there is no incentive for new programs to accept state funding. Thus, expanded private financing of substance abuse treatment has unintentionally widened the gap in care between substance abusers with private insurance and those without it. This is borne out by data gathered by the OSAS from publicly funded programs' waiting lists. During 1985, public programs had monthly waiting lists averaging over 1,000 individuals, the vast majority of whom were indigents or the working poor. These clients remain on waiting lists for an average of six weeks.

It is paramount that clients receive treatment when they seek it. Many of those on waiting lists lapse into denial or become discouraged from pursuing care. Even if they do enter treatment when a program has an opening, it is likely that their conditions have worsened during the waiting period. Failure to treat clients when they seek treatment inevitably increases the likelihood that they will need long-term medical care for their dependency and the numerous other diseases (including heart disease, cancer, and cirrhosis) to which chemical dependency contributes.

Expanded funding for public programs to treat indigent and low-income substance abusers and dependents would certainly help, but the resources of most public programs do not match those of most private programs. More funding would allow public programs to treat more people, but we would still be left with a two-tiered system of substance abuse treatment: privately insured clients are much more likely than public clients to receive intensive care if they need it. To remedy this, state government should require all programs, as a condition of licensure, to devote a percentage of their service units (days for inpatient and residential programs, hours for outpatient programs) to treatment of indigent and low-income substance abusers and their family members.

Unfortunately, the absence of uniform data has prevented the documentation of the gaps in treatment and services. Data are needed on client age, gender, race/ethnicity, family, education, income, employment, history, drug use and treatment history, physical and psychological problems, current treatment plan, and discharge, aftercare, and follow-up. This would facilitate a determination of who is receiving what treatment and services according to demographic variables and severities of dependency. Also needed is information on where and why programs would refer clients if a broader range of treatments and services were available or reimbursed. Requiring all licensed programs to compile uniform data on each client would help identify gaps in treatments and services. The OSAS and its regional coordinating agencies should consider the gaps identifited from the data in their distribution of state treatment funds.

Even extensive data gathering and analysis may do little to encourage innovative new treatment. As Miller and Hester note in "Inpatient Alcoholism Treatment: Who Benefits?", treatment approaches commonly employed in alcoholism programs have remained substantially unchanged for twenty years.

Unfortunately, new treatment approaches have not evolved from our better understanding of the complexity of substance abuse and dependency.

RECOMMENDATION 16A: Legislation should be enacted requiring all programs, as a condition of licensure, to devote a percentage of their service units (days for inpatient and residential programs, hours for outpatient programs) to the treatment of indigent and low-income substance abusers their families.

RECOMMENDATION 16B: The OSAS coordinating agencies should require all licensed programs to compile uniform demographic and treatment data on each client it assesses or treats. To determine gaps in treatment and services, the coordinating agencies should collect confidentially information from all programs about where and why a program would have referred clients if a broader range of treatment and services had been available. The OSAS and its 18 regional coordinating agencies should consider the gaps identified from the data in their distribution of state funds for treatment.

RECOMMENDATION 16C: The OSAS should continually seek information from bulletins, newsletters, seminars, colloquia, and other forums about treatment innovations. The best should be communicated to program directors and counselors throughout the state.

17. Problem Statement: There is a need to identify and encourage mechanisms to assure appropriate utilization and delivery of services; i.e, the appropriate nature, quality, intensity, and length of treatment(s).

Discussion: Entering a treatment program and receiving the treatments and services most likely to help a chemically dependent person may be two different matters. To improve treatment for substance abusers and the chemically dependent, (a) clients must receive the treatment most appropriate to their dependency (matching); (b) clients must progress without unnecessary repetition or omission through the range of treatments and services outlined in their treatment plans, a responsibility shared by both client and the treatment program (proper utilization of services); and (c) the necessary treatments and services must be well performed (quality assurance).

Advances in assessing the chemically dependent--measuring the severity of dependence, the client's willingness to change, and the personal and social resources available to uphold the change--have improved the ability of substance abuse professionals to match client and treatment. Many obstacles still prevent proper matching, however. We do not know enough about which existing treatment approaches work best for which people (see also Problem Statement 18), and we do not know which new approaches would work best for certain people (see also Problem Statement 16). Other obstacles to proper matching and recommendations to remove them are discussed in the section of this report entitled "Outreach, Assessment, and Referral."

All substance abuse programs are required by state regulation to draw up treatment plans for each client at admission; the plans set out the nature, progression, intensity, and length of treatments and make allowances for unforeseen circumstances that would affect progress. This is the ideal; in reality, much can happen to interrupt the course of planned treatment. Many clients simply drop out. Others float from one public program to another and avoid a long-term treatment plan that may help restore their health.

A significant percentage of the individuals in treatment have been in treatment before. If an individual does not return to the program that previously treated him/her, the treatment professionals at the new program often cannot obtain the client's records. Programs must discuss and exchange client records when necessary. The case managment model outlined in Problem Statement 15 is another way to remedy program shopping and encourage cooperation between programs.

Even if individuals receive the treatment and services most appropriate to their needs, even if conscientious programs work together to make certain that clients are treated without unnecessary repetition, the most difficult question to quantify remains: has the substance abuse professional performed well? The question is very hard to answer for any field that traffics in human behavior and motivation, especially if one wants to avoid punishing the conscientious counselor for the client's unwillingness to help him- or herself. In substance abuse, where there is much disagreement and little conclusive research on which treatment and method work best for which patients, the difficulty of setting standards for quality is exacerbated. Yet practitioners must be held accountable to some extent for the progress of people they treat. The development and implementation of a uniform substance abuse counselor credentialing system, already under way in Michigan, is one important way to encourage quality care.

Currently, the OSAS licenses all substance abuse programs in Michigan. Each program is reviewed at least once a year before the license is renewed. On the license application, programs must explain treatment philosophy, methodology, and objectives; admissions, discharge, and follow-up policies; staff/client ratios; and service units provided. The OSAS carries out on-site licensing inspections to review program administration; client treatment plans are inspected to make certain that care and progress have been documented and that the program has maintained the policies outlined on its application. To receive or retain a license, a program must document that it is performing as it said it would in the application. Licensing, then, depends on what services are performed, not on how well they are performed.

The Joint Commission on the Accreditation of Hospitals evaluates the quality of treatment more than state licensing does, although accreditation still hinges on administrative rather than performance review. Some third-party insurers, including Blue Cross/Blue Shield, require JCAH accreditation for reimbursement. The OSAS offers technical assistance to encourage all substance abuse programs in the state to meet JCAH standards, although compliance for state licensing is voluntary.

The JCAH accreditation process is expensive and lengthy; it drains important time and money from programs. Some programs cannot qualify for Blue Cross/Blue Shield reimbursement only because they cannot afford accreditation surveys. To remove this obstacle to programs that wish to meet quality assurance standards, state licensing standards could be revised to reflect two levels of licensure: the current standard and a higher standard equivalent to the JCAH accreditation standards. The savings to programs would be substantial: the OSAS licensing units, which already assist programs seeking JCAH accreditation, could review license applications at no cost to the programs.

Reimbursers are beginning to consider a measure of program accountability that goes beyond accreditation to encompass patient outcomes. Do patients overcome their drug dependency at a given program? Do they abstain from drug use after they leave? Such questions invite more complicated ones. Can successful outcome be measured by total abstinence, or should it be measured by improvement (if so, how?) or by abstinence with few relapses, or by "controlled use"? To what extent should a program be held responsible for what a client does after he leaves treatment? Measures of successful outcome must take into consideration the complex of psychological and social factors that may contribute to dependency and progress in treatment. Clearly, a wide range of successful outcomes is necessary to account for the wide range of diagnoses and prognoses among the chemically dependent. The same progress cannot be expected from an unemployed alcoholic without a family who has been drinking heavily for twenty years and from an employed alcoholic with strong family support who has been drinking heavily for three years. Careful exploration of expected outcomes must precede requirements for programs to justify their treatments by the success rate of their clients. Outcome protocols must also be especially careful not to punish programs for treating the chemically dependent with the worst prognoses.

RECOMMENDATION 17A: The OSAS licensing requirements for substance abuse and dependency programs should be expanded to include two levels of licensure, the current standard and a higher standard equivalent to or surpassing the JCAH accreditation standard.

RECOMMENDATION 17B: The OSAS should convene a task force of experts in chemical dependency research, assessment, treatment, program administration, and reimbursement to begin developing definitions of successful outcomes and ways to measure them.

18. Problem Statement: There is a need for research on the effectiveness of treatment.

Discussion: It is commonly thought that one-third of substance abusers recover without any treatment, one-third recover with treatment, and one-third benefit little from treatment. "Scientific evidence on the effectiveness of drug abuse treatment is limited," a recent Rand Corporation study asserts. The fact remains that treatment does help many substance abusers, especially if seen in terms of savings in total health care costs, the criterion of effectiveness in this era of health care cost containment. Several studies show that a substance abuser's total health care costs are significantly less after substance abuse treatment than before.

Determining which treatment and services are best can lower costs even further without sacrificing quality of care. It is in the determination that the research is inconclusive. Further, in an eight-year study of alcoholics and their treatment patterns, Vaillant found that factors outside formal treatment (including family and social supports) played a large part in the success of treatment. This suggests that research is needed to clarify which persons need inpatient, residential, and outpatient care, in which combinations, and for what duration. The determinations must be based on a comprehensive diagnosis of the client's personal, family, and social circumstances, the severity of dependency, and attendant mental and physical ailments.

Lack of communication between substance abuse treatment researchers and the substance abuse treatment delivery system inhibits the exchange of valuable information about treatment. Researchers publish their findings in scholarly journals that counselors have neither the patience nor the time to read. As a result, the latest evaluations of and advances in treatment go unheeded. For their part, counselors and program directors need to tell researchers about their work and about areas of greatest uncertainty in programs and treatment. Creating a forum for researchers, coordinators, program directors, and counselors to share information can help keep everyone apprised of the latest innovations in and evaluations of treatments.

RECOMMENDATION 18A: Public, foundation, and private support should be sought to fund studies of the comparative effectiveness of outpatient, residential, and inpatient care for the various diagnostic groups of the chemically dependent in Michigan. These or other studies also should evaluate the relative effectiveness of treatments for various groups having distinctive needs: women, Blacks, Hispanics, codependents, low-income individuals, adolescents, the elderly, the dually diagnosed (those diagnosed as being both chemically dependent and mentally ill), and others.

RECOMMENDATION 18B: The OSAS should establish a consortium of substance abuse researchers, coordinators, program administrators, and counselors to assure that the newest and most reliable information about substance abuse treatment is exchanged and disseminated.

REIMBURSEMENT

The general population increasingly recognizes the prevalence of chemical dependency and the need for chemical dependency services; nearly everyone agrees that we must devote more resources to this growing national problem. At the same time, cost containment monopolizes the discussions of payers, providers, and consumers of health care in general and chemical dependency services in particular. How can we contain costs and better serve the chemically dependent?

The answer lies in the distinction between cost containment and cost reduction. Cost containment means reducing unnecessary services or providing effective services at the lowest possible cost; cost reduction means simply reducing services or providing them at the lowest possible cost. Cost containment should justifiably be the goal of all health care providers. Cost reduction should not, especially for a major health and social problem such as substance abuse and dependency. Reducing overall expenditures for the prevention and treatment of substance abuse and dependency--at a time when their enormous social and economic costs are only beginning to be recognized--would be an act of bad social faith.

Substance abuse and dependency are, like heart disease and cancer, major health concerns; we should make funding and reimbursement for their prevention and treatment, like that for heart disease and cancer, a part of the health care mainstream. If the goal of health care is to help people lead healthy, productive lives, spending more on substance abuse and containing costs can both be accomplished.

Several studies show that treatment reduces the future overall health care costs of the chemically dependent. In general, treatment is cost effective. Nevertheless, for some people, especially those with advanced alcoholism or other chemical dependencies, treatment inevitably leads to increased health care costs because the physical examination that precedes treatment often identifies numerous medical complications that must also be treated, often in acute-care hospital beds. Health care professionals and payers, reflecting the bias of the public, generally are reluctant to treat or pay for substance abuse care until it precipitates other clear-cut medical problems. Identifying and treating alcoholism earlier would undoubtedly cost less than waiting for alcoholics to develop heart disease or cirrhosis. Identifying and counseling the children of alcoholics would reduce their vulnerability to becoming alcoholics themselves. Other human, social, and economic costs (family violence, absenteeism, traffic accidents) would also be reduced and possibly avoided by early identification and treatment.

Current reimbursement policies discourage flexible, individualized care for substance abusers and the chemically dependent. Many clients need various services in inpatient and outpatient settings; others may need to repeat treatments because of relapse. Unfortunately, services needed and services reimbursed are not always the same.

Many reimbursement policies seem to define "better serve" as "offer expensive services." Medicaid, Medicare, and most private payers reimburse providers for services given in inpatient (hospital-based) and residential settings--the most expensive on the market--and underreimburse for outpatient services--the least expensive care offered by licensed programs. Thus, programs have little financial incentive to provide less expensive care. This severely limits the range of services--the continuum of care--available to many clients. Those who need outpatient care often do not receive it or must pay for it themselves. Payers, providers, and consumers should consider the possible savings and health benefits of services provided in the less--as well as the more--expensive settings. "Less expensive" need not mean "less intensive." Many clients need detoxification and intensive counseling and therapy, but these services do not always have to be offered in the costliest inpatient settings. Sound reimbursement policies can contain costs for consumers, providers, and payers while responding to client needs.

Current funding and reimbursement policies also deprive many of the poor of the care they need. Approximately 11 percent of the Michigan population have no health insurance; the overwhelming majority are poor. State-funded programs, which in theory treat those who cannot pay, do not have the resources to serve many of the poor. Funding and reimbursement policies must better address the substance abuse and dependency treatment needs of indigent and low-income persons.

19. Problem Statement: There is a need to coordinate and interpret existing data on the costs and utilization of the full continuum of chemical dependency treatment and care, including the costs and applicability of alternative models of care.

Discussion: Public and private payers often set reimbursement levels without reference to the range of existing data about costs and utilization of chemical dependency services. Without a statewide clearinghouse, general access to much of the relevant data is impossible. A nongovernmental body of providers, payers, and consumers could be identified or established to coordinate and interpret data from both public and private programs. To remove the time-consuming administrative barriers that yearly contract renewals create, the State should grant a multiyear contract to this consortium. Collecting aggregate data anonymously would increase the likelihood of private payer and provider participation.

Length of stay, relapse rates, total charges, and reimbursement rates by diagnosis have been studied for various treatment settings and programs. Brought together and compared, these studies could shed light on the rationale behind what is charged for given interventions in given programs and, in turn, suggest how costs could be contained without reducing the quality of care. Special attention should be given to information on demonstration and pilot projects having innovative delivery of or payment for care.

RECOMMENDATION 19: A statewide body or consortium should be identified or established and given a five-year contract to coordinate and interpret existing data on costs and utilization of chemical dependency services. This body should include representatives of providers, payers, and consumers.

20. Problem Statement: There is a need for private payers to provide adequate reimbursement for chemical dependency care.

Discussion: Michigan public acts 429 and 430 of 1981 mandate that health insurers provide coverage for a minimum of $1,656 (with yearly adjustments for inflation) of substance abuse care per individual per year. The legislation undoubtedly makes services accessible to more people in need and increases reimbursements to service providers. Nevertheless, a large number of privately insured individuals remain without adequate coverage. The state law, from which self-insurers are exempt by federal law, becomes less relevant as more employers self-insure or require their employees, as a condition of receiving employer-paid health care benefits, to enroll in health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that may limit substance abuse and dependency care. For those covered by P.A. 429 and P.A. 430, $1,656 often does not begin to pay for inpatient or residential detoxification and services.

Prepaid health care plans have inherent disincentives to provide treatment, especially if it is for a disease such as chemical dependency that is still outside the health care mainstream. An investigation in Massachusetts by state Senator Michael Flaherty and anecdotal information suggest that HMOs are postponing care for substance abusers and dependents who seek treatment. Until a reliable standard of care, against which health care providers' efforts to treat can be measured, is established, documenting such problems is difficult. Nevertheless, the OSAS, the MDPH Bureau of Health Facilities (which regulates HMOs), and the Insurance Bureau should undertake a study to determine the extent of the problem and its possible solutions. If called for, legislation should be enacted to ensure that HMOs provide no less coverage for substance abuse and dependency care than is required of other private reimbursers.

The state-mandated minimum also indirectly limits the kinds of substance abuse services a policyholder may receive. As discussed earlier, many insurers reimburse for services in inpatient and residential settings, but not in outpatient settings. Providers have little incentive to offer outpatient or residential services if they will not be reimbursed for them. For their part, insurers are reluctant to reimburse for outpatient services because they have no way of controlling quality and because they have no assurance that paying for outpatient services will reduce use of inpatient services. Counseling and support services for the family members of substance abusers are also rarely reimbursed.

Because public attitudes about the pervasive effects of substance abuse and dependency are changing, because professionals increasingly understand how substance abuse and dependency should be treated, and because the number of health insurance plans exempt from the state law requiring coverage for treatment is growing, mandated minimum coverage should be reconsidered. Legislation could be enacted to (a) raise the minimum amount, (b) change the minimum from a dollar amount to a quantity of service units, or (c) effect some combination of the two. The goal should be to better serve client needs.

RECOMMENDATION 20A: The OSAS, the MDPH Bureau of Health Facilities, and the Insurance Bureau should undertake a study to assess HMOs' and other prepaid insurance plans' commitment to serving those in need of substance abuse and dependency care. If called for, legislation should be enacted to ensure that prepaid insurance plans provide no less coverage for substance abuse and dependency care than is required of other private reimbursers.

RECOMMENDATION 20B: The state legislature should assess the adequacy of the current state law mandating private health reimbursers to cover substance abuse and dependency services and make changes to better serve the chemically dependent and their family members.

21. Problem Statement: There is a need for Medicaid and other federal and state funding sources to improve the mechanisms for reimbursement of chemical dependency care.

Discussion: In addition to its regular coverage of life-threatening medical detoxification in acute-care hospital beds, the Michigan Medicaid program designates 25 hospital-based (inpatient) programs as subacute substance abuse providers. Medicaid reimburses these programs for detoxification and treatment.

Federal regulations for the Medicaid program do not permit states to claim federal matching dollars for substance abuse and dependency services in nonhospital-based settings. The exception is the Alcoholism Demonstration Project. This program, in which the Michigan Medicaid program participates, permits reimbursement for detoxification and residential and outpatient treatment in less costly freestanding facilities. Twenty-two Michigan programs currently participate in this project. Since federal support ended in late 1985, the project has been funded entirely by the Michigan Medicaid program and the OSAS.

The Alcohol Demonstration Project has significantly expanded the range of substance abuse services that are financially accessible to Medicaid recipients. To guarantee that Medicaid continues to reimburse for this wide range of services in less costly settings, state government should allocate new funds to Medicaid to establish the program permanently. By allowing only freestanding facilities to participate, the demonstration project limits hospitals to their traditional costlier role in substance abuse treatment. To encourage hospitals to offer a wider range of services at lower costs, the project should be expanded to include hospital-based providers.

Over time, Michigan laws have constructed a crazy quilt of reimbursement mechanisms to finance substance abuse and dependency treatment. In addition to Medicaid funding, state government (in most cases with federal matching funds) pays for treatment through (a) federal Title XX programs contracted out by the departments of Social Services or Mental Health, (b) Department of Mental Health appropriations for community and institutional care, and (c) OSAS appropriations. These publicly funded efforts are over and above the statutory mandate extending coverage to individuals through private group health insurance.

Through federal block grants, federal matching funds, and state appropriations, the OSAS distributes $33 million to 250 programs throughout the state to serve the needy. The OSAS contracts with 18 regional coordinating agencies, which in turn subcontract with local service providers. (A few local programs receive contracts directly from the OSAS.) By and large, funds are distributed through the traditional public health model of staffing grants, which are awarded to a program based on its staffing and budget. In return, the grantee agrees (a) to provide services to clients with little or no ability to pay and (b) to collect fees when the client is able to pay.

The OSAS staffing grant system has fostered the growth of prevention and treatment programs. However, staffing grants--which are based on program staffing patterns and overall budget and not on services delivered--do not lend themselves to documenting who receives what services. This is a serious problem for a system designed to serve the indigent, the uninsured, and the underinsured.

Unfortunately, the staffing grant approach encourages development of a two-tier system of care, one for the needy and one for wealthier, private payers. This problem could be minimized if the OSAS were to encourage alternative reimbursement mechanisms as well as staffing grants. Alternatives could include fee-for-service arrangements, capitated plans, and a voucher system. Some coordinating agencies already are trying such alternatives on a pilot basis. Another approach would be to shift appropriated funds from the OSAS to the Bureau of Medical Assistance in the Michigan Department of Social Services (MDSS) and to manage reimbursement for substance abuse and dependency within the Medicaid program.

Any change in the funding of public chemical dependency programs in Michigan requires long and careful consideration; changes must be based on the understanding that chemical dependency is a major health and social problem. Unwise funding and reimbursement decisions will exacerbate the problem.

RECOMMENDATION 21A: The State should allocate funding to make permanent the Medicaid Demonstration Program reimbursement of residential and outpatient treatment programs. Hospitals that can provide such care at the rates set by Medicaid should be included in the program.

RECOMMENDATION 21B: To help make substance abuse and dependency treatment a part of the mainstream of health care, the governor or the Advisory Commission on Substance Abuse Services should establish a blue-ribbon panel to study (a) alternative reimbursement mechanisms, including fee-for-service, capitation, voucher models, and others and (b) all state agencies that fund substance abuse and dependency care to suggest ways that they can be coordinated to maximize public funding for prevention and treatment.

22. Problem Statement: There is a need to identify and treat persons who do not have the financial means to get adequate care.

Discussion: An enormous number of people lack the financial means to get the adequate chemical dependency care they need. According to the U.S. Census Bureau's current population survey, 37 million Americans have no health insurance. Over one million people in Michigan--11.4 percent of the population--have no health insurance. Certainly a much larger number have no coverage for chemical dependency services. Fewer than 50 percent of the poor and near-poor have Medicaid coverage. Those on Medicaid who find employment often lose chemical dependency care coverage because their new employer's health plan does not provide it.

Private programs are accepting fewer patients who cannot pay for all or part of their treatment and services. In the past, many health providers could afford to treat the medically indigent through "cost shifting"; that is, they charged private payers (insurers, self-insured companies, and private-paying clients) more to make up for losses incurred in treating those who could not pay. Public and private insurers' efforts to control health care costs in recent years have decreased this practice. Now private programs must often refer clients without health insurance or whose coverage has run out to public programs.

In theory, the OSAS funds treatment programs that serve the uninsured. In practice, however, publicly funded programs have neither the staff nor the funds to serve many of these people. Programs are required to maintain waiting lists for the clients they assess, but they keep no record of whom they turn away without assessing. No one knows how many uninsured people are seeking treatment or the extent of their dependencies. Programs are reluctant to admit turning away patients for fear that the OSAS will not renew their funding. A statewide body or consortium, perhaps the one discussed in Recommendation 19, should collect this information from all state programs. To encourage programs to report these numbers, the information should be kept confidential.

Efforts are being undertaken to serve the uninsured. The Michigan Medicaid program has a grant from the Robert Wood Johnson Foundation to establish a demonstration project to improve health care access for the uninsured. Two pilot sites, one rural and one urban, will serve General Assistance (GA) recipients who are ineligible for Medicaid, those who stop receiving GA or Aid to Families with Dependent Children health care benefits when they become employed, and other low-income uninsureds who are ineligible for Medicaid. The cost of insurance at these pilot sites will be shared equally by the employee, the employer, and a state "last resort fund." To avoid overburdening any of the three, funding is being sought from the General Assistance program, community organizations, and the state legislature. Medicaid administrators are forming a technical assistance group to define the benefits package for the pilot programs; substance abuse professionals should be part of this group.

Awareness is growing that chronic, chemically dependent people comprise a larger and larger portion of the uninsured population. Since detoxification is the only uniform benefit in health care insurance packages, chronic relapsers often move from one detoxification program to another. Because their conditions are often advanced, this chronic population may best be served through long-term sheltered care (housing with social support but without treatment), which would lessen their need for expensive, repeated detoxification. Other recovering chemically dependent individuals need long-term shelter with support services as a transition between treatment and normal life.

Governor Blanchard's Human Service Cabinet has established a task force to look into access by the indigent to health care services. Their deliberations clearly should include the question of indigent access to substance abuse and chemical dependency services.

RECOMMENDATION 22A: All licensed substance abuse and dependency treatment programs should be required to report uniformly the number of clients they must turn away and the severity of their dependencies. A statewide body or consortium, perhaps the one recommended in Recommendation 19, should collect this information on a confidential basis.

RECOMMENDATION 22B: The legislature should provide additional funding to Medicaid for the Health Care Access Project, which aims to increase access to health care for uninsured, non-Medicaid eligible persons. Chemical dependency treatment and services should be an integral part of the project's benefits package.

RECOMMENDATION 22C: The departments of Mental Health and Social Services, the OSAS, and the Veterans Administration should establish a network of sheltered care facilities for persons who need a long-term supportive environment.

RECOMMENDATION 22D: Governor Blanchard's Human Services Cabinet's indigent care task force should consider access to substance abuse and dependency care in its study of indigent access to health care services.

GLOSSARY

ALCOHOLICS ANONYMOUS (AA): An international organization of alcoholics devoted to the maintenance of the sobriety of its members through self-help and mutual support. Membership in AA is voluntary and members pay no dues or fees.

ASSESSMENT: A substance abuse practitioner's evaluation--usually based on an interview or questionnaire--of the extent of an individual's substance use and his/her personal and social circumstances to determine which, if any, treatment services are needed.

CAPITATION: A method of paying providers of health care. The provider receives a flat fee for each client, regardless of the frequency with which services are used.

CASE MANAGEMENT: A system of service delivery in which each client has a case worker who monitors the client's needs and assists him/her in obtaining services.

CHEMICAL DEPENDENCY: Traditionally defined as an illness in which drug users find it difficult to stop or control drug use either because they feel they cannot function without the alterations in perceptions or feelings induced by drugs (psychological dependency) or because habitual use has so altered their body chemistry that they will suffer withdrawal symptoms if they cease drug use (physical dependency.) See DRUG.

CIRRHOSIS: A chronic inflammatory disease of the liver in which scar tissue replaces functioning liver cells. The vast majority of cases, particularly in the United States, result from chronic alcohol abuse.

COCAINE (COKE): An alkaloid found in the leaves of the cocoa bush and usually sold as a white powder. Cocaine affects the central nervous system and induces feelings of euphoria.

CODEPENDENCY: The detrimental psychological and physical effects of a close relationship with a chemically dependent or substance abusing person. Codependency often manifests itself in depression, low self-esteem, and compulsive behavior.

CONTINUUM OF CARE: The wide range of services that a substance abuser or dependent may need during the course of recovery. Example are detoxification; individual, group, and family counseling; structured work and recreational activities; instruction about substance abuse and dependency; support services, such as education, vocational counseling and training, and Alcoholics or Narcotics Anonymous; and aftercare.

COORDINATING AGENCIES: The eighteen regional agencies that receive public funds from the OSAS and, in turn, distribute these funds to local substance abuse service programs. The coordinating agencies also assist and evaluate programs and develop plans for local delivery of substance abuse services.

CRACK: A crystalline form of cocaine that can be smoked.

DETOXIFICATION: The elimination or reduction of the amount of a drug in the body. After detoxification, the patient is able to abstain from the drug without severe physical discomfort and is no longer physically dependent upon it.

DRUG: Any chemical substance that produces physical, mental, emotional, or behavioral change in the user. In this report, "drug," "chemical," and "substance" are used interchangeably.

DRUG ABUSE: According to the United States Food and Drug Administration, "deliberately taking a substance in a manner that can result in damage to the person's health or...ability to function."

DRUG MISUSE: According to the United States Food and Drug Administration, "taking a substance for its intended purpose, but not in the appropriate amount, frequency, strength, and manner."

DRUG PARAPHERNALIA: Equipment used for smoking, injecting, inhaling, or otherwise using drugs; for example, water pipes and cocaine spoons.

DUAL DIAGNOSIS: A diagnosis of both mental illness and chemical dependency.

EMPLOYEE ASSISTANCE PROGRAM (EAP): A program, administered within a business or by an outside service provider, that helps employees and their families with substance abuse and other personal problems that affect health and job performance.

FETAL ALCOHOL SYNDROME (FAS): A disorder--often characterized by mental retardation, deficient growth, and physical abnormalities--that afflicts children born to mothers who used alcohol excessively during pregnancy.

FREESTANDING FACILITY: A facility not physically attached to a hospital.

HEALTH MAINTENANCE ORGANIZATION: An organization that, directly or through contracts with affiliated health care providers, delivers health care services to subscribers in exchange for a fixed prepaid sum.

HEROIN: A narcotic derived from morphine usually sold as a white, crystalline powder. Heroin depresses the central nervous system, relieves pain, and induces varying degrees of euphoria.

LEVELS OF CARE: The three general categories into which substance abuse and dependency treatment is usually divided. Inpatient care is medically supervised 24-hour-per-day treatment for persons in medical/surgical or psychiatric hospital beds. Residential care is 24-hour-per-day treatment provided either in a freestanding facility (not physically attached to a hospital) or in a nonmedical/surgical hospital bed. Residential care can be divided into intermediate, long-term/therapeutic community, and long-term/halfway house. Outpatient care is treatment in a nonresidential setting; the substance abuser does not live at the program facility, but continues to receive counseling there.

LIFE SKILLS DEVELOPMENT TRAINING: Training for young people in social skills needed to resist pressures to experiment with and abuse alcohol, tobacco, and other drugs.

LONGITUDINAL RESEARCH: Research that follows the subjects of study over long periods.

MARIJUANA: The dried flowering tops, leaves, and stems of the Indian hemp plant. Marijuana is usually smoked and can produce hypnotic and hallucinogenic effects, time and space distortions, enhanced sensory perception, euphoria, anxiety, and paranoia.

MEDICALLY INDIGENT: Those whose health care expenses, in whole or in part, are not covered by insurance and cannot be paid out of pocket.

MEDICAID: A state-administered health care program that uses a combination of state and federal funds to pay for predefined medical care for individuals (a) enrolled in categorical programs such as AFDC or SSI or (b) whose medical expenses exceed their ability to pay (the medically indigent). The Medicaid program is authorized by Title XIX of the federal Social Security Act.

MICHIGAN MODEL FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION: A comprehensive health curriculum for K-12 students developed for statewide use by the Michigan departments of Public Health, Education, Mental Health, and Social Services, and the offices of Substance Abuse Services, Highway Safety Planning, and Health and Medical Affairs. The curriculum contains material on substance abuse and dependency.

NARCOTICS ANONYMOUS (NA): An organization composed of individuals who meet regularly to help each other facilitate their recovery from drug addiction. Similar to Alcoholics Anonymous.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA): A part of the Alcohol, Drug Abuse, and Mental Health Administration that is charged with providing leadership, policies, and goals for the federal effort in the prevention, control, and treatment of drug abuse and dependency, and the rehabilitation of affected individuals. NIDA also conducts and funds research in these areas.

OFFICE OF SUBSTANCE ABUSE SERVICES (OSAS): An autonomous agency within the Michigan Department of Public Health charged with the implementation of state and federal substance abuse services legislation. Its biggest function is to administer and coordinate all public funds for substance abuse prevention and treatment. OSAS also assists, evaluates, and licenses services providers; sponsors training programs for substance abuse counselors; and collects and disseminates information and educational materials about drugs and substance abuse and dependency.

OUTREACH: Any systematic attempt to identify persons in need of substance abuse services, alert persons and their families to the availability of services, and help persons obtain assessment and, if necessary, treatment and other services. Also called "casefinding."

PARENTING TRAINING: Classes for parents that teach skills for dealing with their children in ways that encourage responsibility and self-confidence in the children and constructive parent-child relations.

PREVENTION: Primary prevention--efforts intended to reduce experimentation with potentially dangerous substances; secondary prevention--efforts intended to prevent substance use from becoming abuse or dependency; tertiary prevention--efforts intended to limit the health and social consequences of developed abuse and dependency problems.

SCHEDULE II DRUGS: According to the federal government classification system, drugs that have currently accepted medical uses in the United States, but have the highest potential for abuse or dependency among controlled medications.

STUDENT ASSISTANCE PROGRAMS: Programs in schools that provide individual support for students at high risk of developing substance abuse or dependency problems and refer them to appropriate agencies outside the school when necessary.

SUBSTANCE ABUSE ADVISORY COMMISSION: The eleven-member commission appointed by the governor to counsel the OSAS ~~administrato~~r on the coordination and administration of substance abuse services. The commission also advises the governor and legislature of the nature and magnitude of substance abuse problems in Michigan and recommends changes in state programs, statutes, and policies that will improve the state government's response to substance abuse problems.

TRIPLICATE PRESCRIPTION: A prescription form containing three copies: one to be kept by the prescribing physician, one to be filed with the State, and one to be kept by the pharmacist. Triplicate prescriptions are intended to facilitate monitoring and controlling the distribution of prescription drugs.

APPENDIX

STUDY GROUP PARTICIPANTS

Chair

Neil Carolan
Director
Chemical Dependency Program
Catherine McAuley Health Center

Vice-Chair

Mary Morin
Executive Director
National Council
on Alcoholism/Michigan

Members

John Abbey
Ford Motor Corporation
Research and Engineering
Medical Services

Nancy Baerwaldt
Associate Vice-President
Public Affairs
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Jesse Bernstein, ACSW, CSW, CEAP
President
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Washtenaw and Livingston Counties

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Northville Regional
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Assistant Administrator
for Finance
Northwest General Hospital

Jean Carlson
Deputy Commissioner
Office of Policy and Compliance
Insurance Bureau

Dee Caudel
Help Program
Hutzel Hospital

James Childs
Aetna Life and Casualty

Jan Christensen
Deputy Director
Office of Substance Abuse
Services

Margaret Clay, Ph.D.
Human Services Consultant

Deborah Comstock
Marketing Specialist
Eastwood Clinics

Julie Croll
Assistant to the Director
Bureau of Health Services
Department of Licensing and Regulation

Jeannie Knopf DeRoche
President
The Knopf Company

Gerald De Voss
Project Manager
Substance Abuse Project
Department of Psychiatry
Michigan State University

Professor Ted Dielman
Dept. of Postgraduate Medicine &
Health Professions Education
University of Michigan

Ruth Evens
Coordinator
Substance Abuse Control
Oakland County Health Division

John V. Farrar
Executive Director
Community Commission on Drug Abuse

Dana Gire
Substance Abuse Services
Macomb County
Mental Health Services

Ms. Arlene Narlock
4620 Compton Court
Sterling Heights, MI 48310

June 26, 1989

Dear Senator Riegle:

Your letter arrived today like a breath of fresh air. Words cannot express my appreciation of your interest in the disgraceful condition of health care in our country.

Although I am unable to drive to Southfield, I would be most pleased if you would include this, my testimony, in the official transcript of the hearing. Here goes!

In January, 1983, my husband of 24 years walked out on his family. Thanks to our short sighted & very harmful to women no-fault divorce in Michigan, our marriage was terminated in 1985. At that time I was working part time and I was awarded adequate alimony (highly taxed) for a 3-year period. My health had not yet begun to slide to it's present dire condition. In 1986 I took some classes & progressed to full-time employment with fully comprehensive health benefits.

In 1987, my back & neck pain & emotional problems escalated to such a point that I could no longer work. I

Ms. Arlene Narlock
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left the work force in Feb., 1988. Since that time the condition of my physical & mental health has continued to deteriorate. In my back I have arthritis, scoliosis, Spina Bifida. Today I underwent a C.A.T. Scan of my lower back to try to determine what exactly is the cause of all this pain. Also, X Rays of back & right knee. Last September, for no apparent reason, I fell down, landing on my right knee & spraining my left foot. If all this isn't enough, I have developed a bleeding ulcer, heatal hernia, migraine headaches, a heart condition, etc., etc., etc. In March, 1988, I applied for Social Security Disability, being fully aware that I am now unable to provide for myself. After I was denied the benefits I am entitled to twice, I enlisted the aid of Disability Services in Novi to represent me. My representative is Ms. Belinda Cooper. On May 3, 1989, I had a hearing before Judge Thomas J. O'Dowd. Again I was denied, based on my appearance. I don't look disabled. Based on his denial brief, Judge O'Dowd was prejudiced against me the moment he

Ms. Arlene Narlock
4620 Compton Court
Sterling Heights, MI 48310

laid eyes on me.

I have a great deal of medical evidence, the best of which Judge O'Dowd discounted. I would be happy to send you copies of everything I have.

My case is being appealed again, but it all takes so long.

I have used up all my resources, the last of my divorce settlement being an IRA which was liquidated at a 30% penalty. That was worth $4,000.00. Almost 800.00 went to pay state & federal taxes. Up to this time I have managed to pay for my own Blue Cross. I pay $148.+ every two months. Out of this I still have to pay for prescriptions (one of which costs $120.00 per month), office visits, co-pay, emergency room & hospital doctors fees & Chiropractic therapy which keeps me mobile.

I am unable to get medical assistance or general assistance because my very unpredictable 1985 Dodge Omni is "worth too much" for me to qualify for anything except food stamps. I have no income and have been reduced to appealing to my church for benevolence. My pride & dignity have been taken from me, having gone

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through the legal, medical, & social systems of our great land.

I have always been a good, productive citizen – a woman of high caliber. I am now living on what is left of my credit. I own my mobile home, but pay lot rent which increases every September. I am approximately one month's rent from being on the street.

This country's leaders wring their hands about the homeless people of our land, yet stories like mine can be multiplied over & over again. Life in our culture has become cheap. Value is placed on "quality of life" rather than "sanctity of life". This is a great moral wrong.

Please forgive my rambling. There is so much more to say, but I am very weary & one step away from another emotional breakdown.

Thank you so much for taking an interest in me, the new American poor. May God bless you in your efforts to help those who will probably never be able to help you. I am

Sincerely,

Arlene M Narlock

Dear Senator Riegle,   7/12/89

I was pleased to hear that you had a hearing on Health in Southfield, Michigan. Unfortunately I was unable to write you before now, but would like you to consider what I have to say. I am a single parent of a seven year old boy, who is asthmatic and very hard to insure. For the last three months I have been shopping around for affordable health insurance for my son. I currently have him covered by Blue Cross/Blue Shield through my insurance at work which cost me 47.22 a week four times a month. He is also covered by Services for Children with Special Needs through Washtenaw County Department of Health. This service covers only asthma related conditions, which I am greatful for. BC/BS does not cover all his bills and that is when Services for Children with Special Needs steps in and pays the balance, that BC/BS does not deem responsible for.

You must understand it has been a struggle for me as a parent of a asthmatic, to continue my education and finally work in my profession, as a photo retouched). And I am very disillusioned by the reality of the health benefits offered not only in our state but our country as a whole. I also have to feel for those who do not have health insurance at all.

I think the one thing that makes me very angry is that our goverment has allowed BC/BS to be a non-profit organization. But stands by and lets them support lobbist, advertise on T.V., radio, and in the papers. They have very luxurious buildings, and highly paid administrators. While I help support this on my $6.00 hour income.

I think the time has come in this country were we are in desperit need for a major change in the health care system. We have elderly people who buy their medicine then can not buy food. We have people like myself who pay for their kids insurance and can not pay rent. Is this the kind of country you want to represent? I think not. I beleive the answer is Socialized Medicine.

Thank you for your time.

Sincerely,

Susan L. Foster-DeFazio
[illegible]87 Milan-Oakville Rd.
Milan, Michigan
48160

NATIONAL COUNCIL ON ALCOHOLISM
LANSING REGIONAL AREA, INC.

June 28, 1989

Honorable Donald W. Riegle, Jr., Chairman
Senate Finance Subcommittee on Health
Dirkson Senate Office Building
Washington, D.C. 20510

Dear Senator Riegle:

Please accept this written testimony for the hearing on "Health Care for the Uninsured" on behalf of the National Council on Alcoholism/Lansing Regional Area.

The problem of health care for the uninsured is dramatically illustrated by our experience during this past year. The National Council on Alcoholism/Lansing Regional Area, has been providing treatment services to the mid-Michigan area for the past twenty-eight years. Our services are highly respected and heavily utilized because of the quality, cost-effective manner in which they are provided to all eligible individuals, regardless of their ability to pay. NCA/LRA has responsibly and aggressively sought ways to maximize all sources of revenue, particularly third party reimbursement, as a way to protect our public dollars for individuals who could not afford to pay for services and who had no insurance. For the past six years of our operation, we have anticipated that 50% of our clients (some 1200 admissions annually) would have health insurance that would reimburse for services or would otherwise have an ability to pay our full fees. This picture has been altered very drastically.

Since October 1, 1988, the number of insured clients, or clients with an ability to pay our full fees for services, has dropped from 50% to 30%. This has occurred at the same time that the employment status of our clients is higher than ever before. The number of people seeking our services, who are fully employed, is up to over 62%. The average income of this client is, however, $12,230.00. AND, these individuals have no health insurance. Additionally, the number of individuals seeking our services, who have HMO coverage, is up 100%, from 8% last year, to almost 17%. HMO's will NOT reimburse for our services - services that are not available anywhere else in the area.

The irony is that while our clients are fully-employed, they have no health insurance, very low paying jobs, and actually have less ability to pay for services than if they were on public assistance, such as Medicaid, that would reimburse NCA/LRA.

NCA/LRA 3400 South Cedar Suite 200 Lansing, Michigan 48910-4606 517/887-0226

The result of this situation has been a $150,000 projected fee shortfall. With no cash reserves, this has meant budget reductions in this same amount. This has meant staff reductions which in turn means fewer services to fewer clients. All of this is occurring at a time when the demand for our services is greater than ever.

We received some emergency financial assistance from our local and state funding sources, to help us through this current fiscal year. Starting October 1, 1989, however, we will be on continuation level funding for the fourth year in a row, and will provide 4,000 fewer hours of services to clients.

We wonder how many people, like the employed, but uninsured and underinsured who have sought our services in the past, will be able to keep their new-found jobs if their substance abuse problems go untreated. We wonder how many of these people will show up in our hospitals and emergency rooms, in need of acute care, because they were unable to receive earlier intervention through services like ours. We wonder how much more room there is in our prisons for these people whose untreated substance abuse problems resulted in criminal acts.

The truth is that there are limited health care services for the uninsured and the situation is worsening. Federal and State support for substance abuse treatment services is decreasing, putting access to care out of reach for the uninsured. Many of the people who seek our services, have already been told elsewhere in the community that without insurance, they could not receive services. Now we, for the first time in our history, must restrict the number of uninsured as well. We can only provide those services that SOMEONE is willing or able to pay for. The responsibility must be shared between the government, the employer and the individual. For our part, we will maintain our commitment to high-quality, cost-effective treatment services.

Thank you for the opportunity to provide this written testimony.

Sincerely,

NATIONAL COUNCIL ON ALCOHOLISM
LANSING REGIONAL AREA

Nancy L. Siegrist

Nancy L. Siegrist
Executive Director

NFIB

National Federation of
Independent Business

WRITTEN
STATEMENT OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before:	**Senate Finance Committee Field Hearing Panel**
Subject:	**Affordable Health Insurance**
Date:	**June 28, 1989**

NFIB is a voluntary membership organization with over 580,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

For NFIB members like Mr. Erwin and their more than 7 million employees, much is at stake in the current debate over mandating health benefits. Mr. Erwin's statement expresses in real life terms precisely what our data explain in statistical terms--that despite the desire to help their employees, small firms are being priced out of the health insurance market and sometimes, out of business.

While NFIB is a recognized authority on small business, NFIB is not an expert in the health care industry or in the insurance industry, therefore remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here.

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The Guardian of
Small Business

NFIB has conducted three national surveys in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. A third is in the process of being thoroughly analyzed; however, the preliminary results are very interesting and are shared later in this statement. In addition, the rising cost of health insurance was the number one problem as first reported in NFIB's 1986 Small Business Problems and Priorities. It was also one of the top concerns raised by the 1986 White House Conference on Small Business.

MANDATE Results

NFIB constantly polls its membership. No position on legislation is taken without approval of a majority of the membership. On the issue of health insurance and health care, small business owners have been loudly registering their concern over the focus of the debate. Mandates, massive expansion of federal government programs, national health insurance, or Canadian system mimicry ignore and exacerbate the real problem for small business--rising health insurance costs.

In April 1987 an overwhelming 89% opposed mandated health insurance (7% favor, 4% undecided). In 1989 small business owners again registered their overwhelming opposition to mandated health insurance legislation.

A consistent finding of our research is that the number one problem facing small businesses is the cost of health insurance. This conclusion was evident in 1986 when out of seventy-five issues polled (from taxes to unemployment compensation to utility rates), the cost of health insurance ranked number one -- even above liability insurance, which was at that time in a crisis state. The problem with the cost of health insurance continues to remain at the top in 1989. In fact, in the newest NFIB comprehensive health study, an astonishing 89% listed health insurance as becoming prohibitively expensive.

Small Business and Health Insurance

The 1986 survey by the NFIB Foundation, entitled Small Business Employee Benefits, revealed that the number of small business owners providing employee health insurance had steadily increased since 1978. The 1989 survey reveals that coverage has since stabilized.

In 1989, as in 1986, sixty-five percent of small businesses offered health insurance for at least some full-time employees. Increases in the coverage rate since 1978 have been most notable in firms involved in financial services, professional services, retail, and the smaller firms -- the very same firms held responsible for the alleged increase in the uninsured population. The troubled, and difficult to insure, agricultural sector continues to be the only sector that reduced coverage. NFIB field survey data from April, 1987 indicate as many as seventy-five percent of those providing fringe benefits are providing health insurance. This is despite the fact that in 1985, the median monthly health insurance premium paid by small employers was more than double the premium in 1978.

Small businesses tend to offer a hierarchy of benefits which expands as the firm matures and size increases. Small business owners as a group provide their employees with a wide variety of benefits, paid vacations and health insurance being the two most commonly offered. In addition, larger small firms are most likely to provide a wider selection of benefits to a larger number of employees than are the smallest firms.

Well over 80% of the health insurance plans offered in small firms carried an option for dependent coverage; however, fewer part-time employees were offered coverage and usually only after a vesting period with the firm. Yet, the majority of small firms offering coverage paid 100% of the premium costs, in sharp contrast to their larger counterparts.

No single reason dominates a small firm's decision not to offer health benefits. The most frequently cited reasons for not providing health care coverage to all employees were: premium expense, employee turnover too great, generally covered under a spouse or parent policy (secondary wage earners), firm insufficiently profitable, and cannot qualify for a group policy. The latter two received the heaviest response rate in the 1989 study.

Small Business in 1989: Preliminary Survey Results

In 1986, NFIB first identified the cost of health insurance as the number one problem facing small business. When asked in 1989 whether the "cost of health insurance is a serious business problem," 66% strongly agreed and 26% agreed with that statement. In addition, 89% found health insurance becoming prohibitively expensive, and respondents offering health insurance had seen increases in premiums in the past year.

Contrast the above to some of the attitudes held by small business owners. First, 71% believe that every American has a right to basic health care, and 74% believe that Americans should receive a minimum level of health care, regardless of their ability to pay. It is at this juncture, however, that small business owners part company with many policymakers in Congress. Small business owners do not support mandated health benefits for businesses or even those directed at individual purchasers. They also do not support raising taxes to increase access to health care for low income individuals, much less for the 38% of uninsured individuals who reside in households earning $20,000 or more a year. Since 1978, a consistent finding has been that small business owners believe individuals have the first responsibility to see that they have health insurance coverage.

The cost of health insurance is posing a dilemma for small firms. Many believe that increasing costs are (or will) make it difficult to compete, and only a minority believe that such costs can be fully passed on to the consumer. Small firms are also discovering that employees prefer wage increases to benefit increases. The younger or more part time the firm's workforce, the greater that preference. In addition, the majority of small business owners do not believe that they have lost good or potentially good employees because of inadequate health benefits. These mixed signals coupled with dramatically increasing costs and low business profitability (over 40% reported that they could earn more working for someone else) do not bear out much hope for encouraging small firms who do not currently offer insurance to do so. Market pressures and employee preferences do not appear to be driving forces in the current debate.

Preliminary analysis of the 1989 survey has raised two interesting features of the small business health insurance market. First, most small business owners do not believe that insurers aggressively compete for their business. Second, of those who do not offer coverage, many independently responded that they were "too small" to get coverage. As in the past, it appears that small firms remain the stepchildren of the insurance industry. High overhead and marketing costs make the small business sector an undesirable target. It is also difficult to fashion cost containment packages for small firms because of the unique dynamics of a small company such as adverse selection, employee turnover, and inability to self insure.

Any downturn in the economy will also have a significant impact on the availability of health insurance as a fringe benefit. Our data strongly suggest that the offering and/or "richness" of this fringe benefit is directly related to business profitability.

Clearly, the policy solution lies with incentives--for both individuals and for small firms unable to afford coverage. Sixty-two percent of small business owners support the government taking a more direct role in bringing health costs under control. Incentives may be the key to unlocking the problem of premium costs, the problem of health care costs lies elsewhere.

Small Firms and Unaffordable Health Insurance

Providing health insurance is much more costly to small firms than to their larger counterparts. By their very nature, small firms are labor intensive and employ many part-time employees. In addition, most small business owners have lower median incomes than wage and salary earners. Clearly, the fat has been trimmed.

Several external factors enter into the equation in determining insurance coverage. First and foremost, small firms are generally unable to self-insure, thus they are forced to operate under the ruberic of costly state health insurance mandates. While discussed later in this statement, state health insurance mandates drive up the cost of health insurance for firms that purchase in the open marketplace and preclude the offering of "barebones" insurance policies. The lack of affordable "barebones" catastrophic insurance keeps both small firms and individuals out of the market.

Second, according to recent Health Insurance Association of America (HIAA) estimates for 1988, premiums in small firms run 15 to 25 percent higher than those of large non-self-insured firms. The Small Business Administration estimates that administrative costs for small firms can be as much as 40% higher than their larger counterparts.

Third, more than two-thirds pay the entire premium, and a whopping 87% pay more than half. In addition, small employers are more generous than large employers when family plans are offered. According to the Small Business Administration, of those firms offering family health insurance plans, 70 percent of the very small firms (1-9) and 55 percent of 10-24 employee firms, but only 34-35 percent of larger firms, pay the entire premium for family coverage.

Fourth, the cost/benefit ratio for small firms is also skewed against small firms. Of each $100 paid in premiums, small firms derive only $75 in benefits, whereas large firms receive $95 (Nexon, 1987). The reasons for such a differential in both the benefits ratio and higher premium costs include: lack of economies of scale, cost of administration, insurer fear of adverse risk selection, instability in the firm, and the lack of expert help in selecting insurance plans.

Fifth, HMOs and managed care systems are not aggressively marketed to the small business sector for many of the reasons outlined above and because small firms tend to be very traditional in their choice of health care providers. Thus marketing requires a greater basic educational level. Compounding the problem is a plethora of state laws restricting HMOs.

The problem of the start up, marginal and "high risk occupation" firms are also important factors in determining the ability to obtain health insurance. Underwriting practices routinely exclude these firms or refuse to offer "discount" group rates.

A Solution: Cost Containment, Development of Incentives and Removal of Barriers

As mentioned previously, the system of incentives has worked. This Committee should consider expanding the incentive approach in the following fashion:

1. The tax laws give a distinct advantage to the business owner who operates in the corporate form as opposed to the business owner who operates as a sole proprietor or partner. In the corporate form, the owner's full health insurance costs, as well as those of his employees, are deductible as business expenses, while for the self-employed, only the health insurance costs attributable to the employees are fully deductible.

The Tax Reform Act of 1986 made a move in the right direction by allowing 25 percent of the cost of the self-employed business owner's health insurance costs to be deductible. However, this partial, and now targetted for extinction, deduction denies the self-employed business owner the incentives given to the corporate business owner to obtain health insurance from him/her and the firm's employees.

According to a 1985 study by the Employment Benefits Research Institute (EBRI), 22.4 percent of self-employed business owners carry no health insurance. These business owners make up between six and sixteen percent of all uninsured workers. Full deductibility, therefore, would address a significant portion of the health insurance gap that exists simply by equalizing the treatment for incorporated and unincorporated businesses.

2. Provide a tax deduction or credit for individuals to purchase their own health insurance. The credit/deduction should be targetted to low income families with children. While access to health care has developed into a right, it is not the obligation of the employer to ensure that right. Rather individuals, attached or not attached to the workforce, should be provided with assistance in affording the purchase of health insurance. The deduction should be limited to premium assistance and be available regardless of whether a taxpayer itemizes or meets a threshold.

3. Allow for a partial refundable tax credit or payroll tax credit for the cost of the benefit for small employers who provide health insurance. This type of deduction would be targetted towards the sizable number of small firms who do not have taxable income and hence are unable to take advantage of the current deduction.

In addition, a whole range of other problems occurs with the disincentives currently in place in the law. Appendix 1 illustrates this point.

1. State health insurance mandates. Clearly, the most troublesome disincentives is the cost of health insurance and health care. One relatively simple way to lower health insurance costs is to preempt state health insurance mandates. State mandates for specific types of benefit coverage now number over 690. These state mandates have seldom surfaced as a result of constituent demand,

but rather have been initiated by well-organized special interest groups, including the providers of services themselves. State mandates range from coverage of wigs (MN) to herbal medicine (FL) to in vitro fertilization (proposed-OH) to special diets for people with Crohn's disease (Mass). Together, they preclude the offering of "barebones" affordable policies for non self-insured companies--the majority of whom are small businesses.

The end result of benefit mandates has been a remarkable growth in the number of providers performing the mandated service -- providers who suddenly find that payment for all services is available, indeed mandated, by state law. In Wisconsin, the passage of a mental health mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years. A similar mandate is contained in S. 768.

In Maryland, state mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross/Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Current estimates tag that increase near 20%. Mandates eliminate the cost control mechanisms provided by comparative choice and increase the cost of health services.

Benefit mandates make coverage prohibitively expensive due to the legislative dictates of the package's components. They take away the right of the insurance purchaser to select and pay for coverages based on the needs of the workforce and the ability to pay. Buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates. S. 768 with its "well baby" and "mental health" provisions is headed down this costly path.

2. COBRA. At a minimum, reform of COBRA is also necessary. Simple changes, such as requiring election of continued coverage two weeks after termination of employment, increasing the administrative fee to reflect actual costs, changing of dependent coverage requirements to preserve the status quo rather than providing an independent right to enhanced coverage, and quarterly advance payments would go a long way to helping relieve some of the costly burdens COBRA has placed on small firms.

3. Costs. All involved in the health care field bear some responsibility for the escalating costs, including individuals who are no longer purchasers, but simply middlemen between the health care provider and the insurance carrier. Active consumer participation is necessary to control costs and regulate service usage. In addition, the issue of the burden of uncompensated care in non-profit hospitals must be balanced against the billions of dollars of foregone local,

state, and federal tax revenue. This forgiven tax burden is borne by the rest of the business community. In return for such enormous tax relief, hospitals have willingly entered into social compact to provide charity care and that obligation should not be assumed by the federal government.

Protocols and liability/malpractice tort reforms should also be examined as part of the solution to drive down the cost of health care. Cost containment is the cure for the disease of limited access to quality health care. With effective cost containment, the symptom of the uninsured will be treated.

Conclusion

There are ways to encourage the expansion of health insurance coverage to employees of small firms, other than mandating coverage. A better alternative is to put small business on a footing more equal with their larger competitors -- equalize the health insurance premium deduction for the self-employed business owner, provide equal protection from state benefit mandates, explore the development of workable incentives to small firms--including expanded tax incentives, and remove government-erected disincentives to providing coverage.

Much of the problem, though, is structural. First, we have just been through a period of record numbers of new business startups. Those marginal firms coupled with firms that leave the marketplace make up a significant portion of the small business community, roughly 20% at any given time, who are unable financially to provide significant fringe benefit packages or unable to obtain coverage because of their insufficient or nonexistent experience rating.

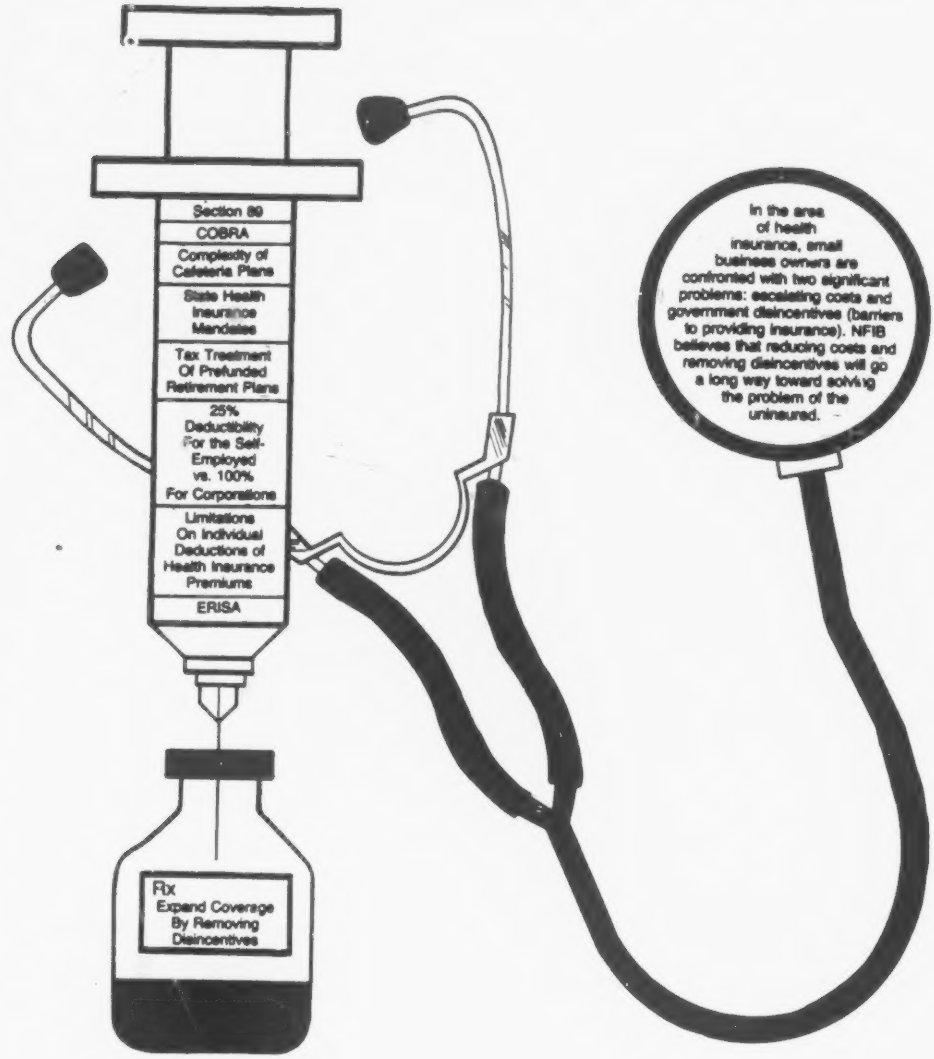
Second, the data we have indicate small employers provide health insurance benefits when they are financially able. Small firms are responding to workforce pressures to provide benefits comparable to large corporations. The small firm, however, must be given the flexibility to phase in those benefits as the firm matures, becomes more profitable, and as the employees demand such benefits.

I would reiterate that small employers continue to offer health insurance, but it must be kept affordable in order for small firms to retain and expand coverage. Small firms are one of the true victims of the health care cost crisis. The paternal instinct to provide for their employees is alive and well, however, many small firms are precluded from acting on it because of the costs of health insurance.

0364T

Attachment

Government Disincentives To Small Businesses Providing Health Insurance


Section 89
COBRA
Complexity of Cafeteria Plans
State Health Insurance Mandates
Tax Treatment Of Prefunded Retirement Plans
25% Deductibility For the Self-Employed vs. 100% For Corporations
Limitations On Individual Deductions of Health Insurance Premiums
ERISA
Rx
Expand Coverage By Removing Disincentives

In the area of health insurance, small business owners are confronted with two significant problems: escalating costs and government disincentives (barriers to providing insurance). NFIB believes that reducing costs and removing disincentives will go a long way toward solving the problem of the uninsured.

1) Att: MR. DON Riegle
AND SeNAte Finance
SUB-COMMittee.

We feel INSURANCE RAtes ARE Going too high. The COVERAGE you RECeiVE and the Red TAPE INVOLved is getting out of hand. SOME COMPANies Put WAiVER clauses iN their contRActs stating if you have High BLood PRESSURE, DiABEtes, etc. CURRENtLy EXiSting you CANNOT be treated OR COVERED under their Plans until MAYBE 3 yrs. LateR. At their Option they CAN REJECT you.

2)

Where is this plan All going to? With the price of Doctors, medical care in + out of hospitals you cannot Afford to be without Insurance. Select care won't take you on without A group plan and you have to be working, what happens when you aren't and they are one of the companies that have the option of saying they will or will not Insure you At

3) their option. Just NORMAL AiLMENTS ARE Getting too costly, NOT EVEN SAYING CATASTROPHIC PROBLEMS. We need INSURANCES that will COVER EVERYONE, with NO AGE LYMIT, RACE OR COLOR, OR ILLNESS RESTRICTIONS Attached. EVERYBODY WOULD LOVE to be healthy, but we ALL CAN'T be so, we need the HEALTH COVERAGE we CAN COUNT ON AND we need it NOW!!

4)

Just our monthly medications our putting strains on our Budgeted Incomes, since we don't have this coverage. And then we have Doctor visits and medical Bandage and Surgical Hose Requirements And the Lab Tests/ In office Tests/ etc., etc. All fine print out of pocket expenses we need Insurances that will cover our medical expenses.

5) TAKE AWAY the MEDICAL MONOPOLIES SOME Health INSURANCES Seem to have ON US, and MAKE them give us the CARE we all need to be Healthy AMERICANS. Other countries have NATIONAL HEALTH CARE which is Good + BAd we just ASK for Good CARE and COVERAGE At ReasonABle RAtes that we CAN Afford.

Thank you Kindly,
MR. & MRS.
GEVERCER
Of ROSEVILLE

June 27, 1988

Dear Senator Riegle,

In hopes that this letter reaches your eyes, I would like to put a plea in for the people who need help in fighting their battles with insurance companies and big businesses.

These people are individuals, who need bone marrow transplants. I don't know how much you know about this procedure, but it's their last chance at life. Some one, at a high position in the insurance companies, makes the decision that this procedure is experimental/investigative, and will not cover the cost. The transplant expenses can cost from $150,000.00 to $207,000.00, this all depends on where the transplant is done.

These individuals are already under enough stress dealing with their dieases, now they are put under even more. They are told that unless they can pay for the transplant then they must wait for their dieases kill them. I am glad that I am not the person that has to play God and decide that money is more important to a company than an individual's life.

Most everyone that carries an insurance card thinks that all their medical expenses are covered under their policies. Whether they pay their own premiums or they are covered under the companies that they are employed by, this procedure and many other expenses are not paid for by the insurance companies.

Up until about eight months ago, I felt as secure as everyone else with these insurance cards but not any more. Since, becoming involved with helping a friend, who had leukemia and needed a bone marrow transplant, my eyes and mind have been opened to alot of problems. Not only was she fighting the diease but she was fighting the insurance company as well as the company that her husband was employed by. One day she would be told the transplant would be covered and then a couple of days later she would be told that it wouldn't. This was like being kept on a roller coaster ride for her life. No one should be treated or put through this kind of stress.

With the help of our local congressman and union officials, who applied the right pressure, we finially heard by letter that her hospitalization would be covered but not any associated professional charges. As of this date, the bills are still being submitted to the insurance company and we are waiting to find out the final cost to her.

In order that her friends might be able to help her financially, we formed a group known as the C.A.P. FOUNDATION. (C.A.P. stands for Caring About People) We had to become incorporated as well as file tax exempt papers with the IRS. Now, we are hearing and learning about more people that are in the same situation as our friend. We want to help them as well, so maybe, this letter will let you know that even though you have insurance, there are no guarantees that you have coverage. When, you have to go to the hospital and they ask if you have insurance, the answer is YES! BUT, do you have the coverage according to your policy.

There are many questions surrounding a Federal or National Health Care Program and some these questions need to be answered. Where would the funding for this program come from? Who would qualify for the program?

Who would oversee the running of the program? Who and Why do they oppose the program? Fianally, what can we do now to help all these people in need until something is done at a national level?

We are losing people to these dieases not because there isn't treatment available but because they can't afford the cost of the medical transplant. I guess the saying, "Money Talks", is very true. So, how many more of our people have to die needlessly, so that the large companies can show a profit on their annual reports. I believe in my mind and heart that there is an answer to these problems some where out there. We just have to unite as one large voice instead of a few small voices scattered over the states.

So in closing, I would very much like more information on the National Health Care Program and to discuss these problems with some one in the future. If possible, could you respond to this letter so that I will know that our thoughts and pleas are not falling on deaf ears. This is not the only letter I have sent to our local politicans but it seems that some of them do not realize there is a severe problem going on in their state. So, please help us to help these people in need because I was taught as a child to extend a hand to those who can't stand up and be strong on their own. Then some day these same people will be able to help others who need their extened hand.

Sincerely yours,

Ann Spry

Ann Spry, President C.A.P. Foundation

Enclosed you will find some articles that I thought be of some interest.

Ann Spry
9456 Highland
Grosse Ile, Mi. 48138

313-671-6574

WISHING HER WELL Detroit Free Press JAN. 19, 1989

GEORGE WALDMAN/Detroit Free Press

Mary Ann Anglin of Lincoln Park leans over Wednesday to hug her friend Norma Robatchka, who came to say goodbye before Anglin leaves for Seattle, where she is to receive a bone marrow transplant for her leukemia. Anglin and her husband, Kenneth, right, are to leave today.

Lincoln Park woman thankful for 2nd chance

By Dennis Niemiec
Free Press Staff Writer

Mary Ann Anglin believes she has been granted a second lease on life in her six-year battle against leukemia, compliments of someone she doesn't know.

The 40-year-old Lincoln Park homemaker, who will die without a bone marrow transplant according to her doctor, within weeks will become one of the first Michigan leukemia patients to be helped by a non-related donor.

Anglin and her husband, Kenneth, plan to fly today to the Fred Hutchinson Cancer Research Center in Seattle, where she eventually will receive bone marrow from one of 27,810 donors in a Minnesota-based national registry. The donor has not been identified, said her physician, Dr. Augustine Perrotta of Trenton.

The search for a donor outside the Anglin family began several months ago after tests showed that the marrow from Anglin's only sibling, brother Jerry Heflin of Woodhaven, was not genetically compatible with hers. Brothers and sisters are the most likely donors to provide a match, Perrotta said.

Since first diagnosed, Anglin has grown more determined to survive, particularly because of her 7-year-old son, Jimmy, she said.

"At first I felt like 'Why me?' but then I got to thinking — everybody has problems," said Anglin. "Nobody was born with a guarantee. God doesn't stamp on your back that you'll live to 90.

"I'm raising our child in a way so that if I die he'll remember me as someone who tried to beat this. And now God is giving me a second chance at living."

Perrotta said Anglin's on "borrowed time," having outlived her life expectancy by a couple of years. He said the upcoming operation has a "50 percent chance of curing her."

Donating bone marrow is painful, requiring anesthesia and needle punctures in the pelvis, said Perrotta. In Seattle, Anglin will undergo extensive radiation and chemotherapy before the operation. Her hospital stay, which will cost about $150,000, is expected to last more than three months, Perrotta said.

Because a transplant between non-relatives is considered experimental, the Anglins' health insurance, which will pay the majority of the costs, will not cover the procuring and sending of the marrow to Seattle, or about $10,000.

Ann Spry, a family friend, said the Mary Ann Anglin Leukemia Fund has been established to help defray the noncovered costs and living expenses for Anglin and her husband in Seattle. The fund's address is P.O. Box 5337, Lincoln Park, Mich. 48146.

Anglin said she has two regrets: the upcoming months away from her son and the knowledge that others in need of transplants cannot afford them. "People are dying because they don't have bucks," she said.

But Kenneth Anglin, a Ford Motor Co. employee, said his wife has an infectiously upbeat outlook, for the most part. Her attitude is "I'm going out there and I'll be all right. I've got my son and husband to take care of," he said.

Dec 14, 1988 News Herald

Insurance sends mixed messages on transplant

By Marsha Stopa-Harrison
Staff Writer

LINCOLN PARK — Mary Ann Anglin has been on an unexpected, unwanted roller-coaster ride for the past week.

Anglin, 40, was beginning to prepare mentally and financially for a scheduled bone marrrow transplant operation next month in Seattle, Wash., when she was notified last week that Blue Cross and Blue Shield of Michigan would not cover her operation as she had been originally assured.

At the time she got the news, her friends were beginning to organize a fund-raising campaign to cover the $20,000 the Lincoln Park family will need for expenses during the four months Anglin recuperates in Seattle.

The unexpected announcement last week by Blue Cross that it would not cover *any* costs of the $137,000 operation pushed the fund-raising drive closer to $150,000.

AND ON MONDAY, Anglin received notice that Blue Cross would cover only those hospitalization costs defined by her contract, but the costs of testing and obtaining the bone marrow from a donor would be her responsibility.

The bottom line? Anglin now has to come up with about $30,000: $10,000 as an immediate payment to the Fred Hutchinson Cancer Center for the donor's costs and the remainder to cover the expenses for the recuperation period.

At issue in the case is whether or not Anglin's operation is experimental, since the perfect-match donor found through the cancer center's registry is not a relative.

Rudolph Difazio, director of media relations for Blue Cross-Blue Shield, said if there was any indication given that her "experimental operation" was covered, there was a misunderstanding.

DIFAZIO SAID elements of Anglin's operation are "unquestionably on the cutting edge of research," and health insurance plans have historically not paid

See NEWS — Page 8-A

News

Continued from Page 3-A

for that kind of experimentation and research.

He said it is usually left to the research institution to come up with revenues from other sources to cover the research cost of the procedure.

Dr. Augustine Perrota, Anglin's hemotologist, said Anglin was facing "incredible odds" of 1 in 100,000 in coming up with even one donor that matched perfectly. But it is "staggering" to come up with two donors who are perfect matches.

Anglin contracted chronic granulocytic leukemia six years ago, she said. The average age at diagnosis is 40, and the life expectancy after diagnosis is three to five years.

NOW IN THE chronic stage, Anglin said, her leukemia could progress to the acute, advanced stage without warning. When that happens, the estimated 60 percent chance Anglin has of surviving the operation successfully drops to 20 percent.

"I've outlived the three to five years predicted," she said. "The doctor said that's why my chances are so good."

Her friends, neighbor Norma Robatchka and Robatchka's sister, Sandra Sawicki-Klish, have become enraged over what they viewed as Blue Cross' confusing misinformation, since as late as Nov. 9 Anglin had verbal confirmation of complete coverage.

"It comes down to the fact that someone (at Blue Cross) gave out wrong information," Sawicki-Klish said. "Who's playing God at Blue Cross?"

JOHN McCLINTIC, regulations specialist with the Michigan Insurance Bureau, said it is not clear what, if any, authority the state may have in this particular instance.

Anglin's husband, Kenneth, has worked at the Ford Motor Co. Rouge steel plant for 18 years.

Because the health-care plan in which Anglin is enrolled is a written and self-funded plan by Ford and administered by Blue Cross, McClintic said that it may fall under a federal law that preempts state authority over Blue Cross' actions.

AND BECAUSE Ford's plan is self-funded, McClintic said the ultimate decision to pay for the operation probably rests with the automaker.

"The Blues will admit that if Ford tells them to pay, they would do it," McClintic said.

Carl Mantyla, a public relations representative for the United Auto Workers, said the union is examining exactly what benefits Anglin is eligible for under the Ford plan.

Anyone wishing to contribute to Anglin's fund-raising drive can send a check made payable to the Mary Ann Anglin Leukemia Fund to P.O. Box 5337, Lincoln Park, MI 48146.

— Wayne County Chamber of Com

Woman battles odds, insurance company for transplant

By HEIDI HILDEBRAND
Sun Staff Writer

LINCOLN PARK, Mich. — Paducah native Mary Ann Anglin spent much of December preparing mentally and financially for a bone marrow transplant this month in Seattle, Wash.

She already had outlived the life expectancy of someone diagnosed with her disease, chronic granulocytic leukemia, and she beat the odds of finding a perfect match for a donor.

She had been assured that her insurance would cover the medical costs, and friends were raising money to help pay the family's living expenses while Anglin recuperated in Seattle.

Those plans were put on hold last week when Blue Cross/Blue Shield informed her that she would have to pay for most of the $140,000 operation.

The company since has agreed to pay the cost of her hospitalization, but she still has to come up with $10,000 to cover the costs of obtaining and testing the donor's marrow before she can be admitted.

But the 40-year-old Paducah native is turning her ride on an emotional rollercoaster into a source of inspiration.

"I'm scared, of course. That's natural. But I've gotten so angry with the insurance company for messing me around, it gave me a reason to get up in the morning and fight," she said.

Anglin was diagnosed with the form of leukemia six years ago. The average life expectancy after diagnosis is three to five years, and she said her ability to fight the disease has stumped her doctors.

"I should have been dead two years ago. I've never been on hard chemotherapy, and they can't figure out what is different about me because I haven't gone into acute. But they're worried now. It's gone on six years, and (the doctor) is afraid it will go into acute any time," she said.

Anglin's disease is now in the chronic stage but could progress to the acute stage without warning. Doctors are anxious for her to have the transplant before that happens because her chances for a successful transplant would drop from 60 percent to 30 percent.

Until enough money is raised to pay the initial costs for the transplant, she is keeping her spirits up. She said maintaining a positive attitude probably has been the key to beating the disease so far.

"I've got a little boy, and he keeps me going. I want to live to see him graduate from high school," she said. "If I don't feel good, I just put it out of my head and go on. I figure this gives me another chance at living. God is giving me another chance at living, and I'm going to take it."

Bone marrow transplants are used to treat patients with leukemia, aplastic anemia and other blood diseases.

The patient first receives chemotherapy and radiation to kill bone marrow cells and to keep the immune system from rejecting the donor's marrow.

The marrow is then taken from the donor and injected through a catheter in the patient's chest, where the cells enter the bloodstream and travel to cavities in the bones.

Doctors hope the marrow will grow and produce new white blood cells, red blood cells and platelets.

The procedure is the same as that used on Mitchell Landon McKinney, the 6-year-old Kuttawa boy who is in Seattle for

See **MARROW**/back page

■ MARROW

Continued from page 1

treatment of a rare blood disease. Although she doesn't know the McKinneys, Anglin said she calls the treatment center periodically for updates on the child's condition.

Anglin is the daughter of the late Wilbur and Lyda Roach Heflin. She and her husband, Kenneth, a Livingston County native, moved to the Detroit suburb 19 years ago. He now works for the Ford Motor Company, and the couple has a 7-year-old son, Jimmy.

Anglin faced 100,000 to 1 odds of finding a donor who matched perfectly, but doctors came up with two perfect matches.

At first, the insurance company refused to pay any of the costs of the $140,000 operation. The company told her that her transplant is considered experimental because neither donor is a relative.

But her doctors say the transplant is not experimental.

"There are no experimental drugs. It's not anything different than if the donor was a relative," she said.

Blue Cross has since agreed to pay hospitalization costs as defined by her contract, but the cost of testing and obtaining the bone marrow from a donor would be her responsibliity. She has also been notified that doctors' fees are not included in hospitalization.

Anglin must come up with $10,000 as an immediate payment to the Fred Hutchinson Cancer Treatment Center for the donor's costs, and about $20,000 to cover living expenses for the recuperation period.

"My husband has to go with me because I'm not allowed to go through it myself. That's four months with no pay. That's what hurts. Money's hard to come by when you're just an average person," she said.

Two of her friends, Norma Robatchka and Sandra Sawicki-Klish, have organized a fundraising campaign. Robatchka said they raised $3,000 in about a month.

Contributions may be send by check to the Mary Ann Anglin Leukemia Fund, P.O. Box 5337, Lincoln Park, Mich., 48146.

HELPING THE HOMELESS
SOS
SOUTH OAKLAND
SHELTER
431 NORTH MAIN ROYAL OAK MICHIGAN 48067
546-6566

Through a source of private funding in the first six months of 1989 The South Oakland Shelter spent 923.20 for Doctor Visits and 417.77 in prescriptions for our clients.

These expenses included one family of Father Mother and 3 children. The father was working ($4.00 per hour)and they were trying to get a security deposit together.

The youngest child (2 years old) developed pneumonia. Grace Family Practice, the clinic that sees our clients, charges us the lowest possible rate for services. However, Diane required $170.20 in doctor visits and $77.30 in prescriptions. (This does not include a 10 day hospital stay that has not been paid for.) Add to that -- 4 year old fell and mother got the flu -- another $49.00 for doctor visits and $12.59 prescriptions. This family required $309.09 in medical treatment from April 4 to May 5, 1989.

This represents approximately 2-1/2 weeks of father's total net pay.

Due to the demand for space, emergency shelters allow people to stay only up to 30 days, some less time than that.

Had we not had that private funding, or had they not been staying in our shelter, this family faced the choice of not treating their child's illness or finding (or remaining in) a place to live.

I fully realize that hospitals and doctors have expenses to meet and cannot treat patients at no charge. I also realize that medicaid coverage is so low that most doctors and even some hospitals do not even accept it.

However, I also realize that the children in the aforementioned family have had no immunizations and since leaving our shelter are not getting even the barest minimum of medical attention. Does this not leave all of us open to the spread of contageon. We cured polio with a vaccine -- for what purpose if our children do not receive immunizations.

Another shelter guest (single mother with 2 year old child) was working as a waitress and doing fine. She qualified for ADC but did not want it because she chose to work an support herself and her child. However, she did apply for medicaid but had to refuse it when she was told she could only work 4 days a week. In order to support herself and her son she must work at least 6 days. Because she wants to work and not drain the system, she and her son have no medical insurance at all and are literally playing russian roulette with their health.

We need a medicaid system for the poor that meets the needs of the poor.

Respectfully submitted
Lillian B. Schneble
Program Director
6/28/89

PUBLIC HEALTH'S SUBCOMMITTEE ON INFANT MORTALITY

CHAIR,

STATE REPRESENTATIVE ALMA G. STALLWORTH

Thank you for the opportunity to share my concerns with you. Like you, Senator Riegle, I am deeply committed to the goal that every American should have access to health care. As a state legislator here in Michigan, I have worked very diligently to create programs which will make health care services available to more people in Michigan.

I have witnessed one consistent hurdle each time we implement a new program -- "who's going to treat these peolpe?" Each time we develop programs which will make health care services more accessible, we must be sure to create mechanisms which ensure the care is actually going to be available. This step requires cooperation between the medical care community and the state and federal government. Cooperation and team effort are essential if we are to devise workable solutions.

Let me share with you some specific experiences.

I chair the House Public Health's Subcommittee on Infant Mortality and during the month of May my subcommittee held six public hearings around the state in order to investigate the problem of infant mortality and prenatal care. Two specific areas which were addressed were the impact of increasing the Medicaid eligibility for prenatal care to women and children up to 185% of the poverty level and the problem of access to medical care for children in families who are uninsured and ineligible for Medicaid.

Michigan did implement the provisions of OBRA'87 which allow women up to 185% of poverty who are pregnant to be enrolled in Medicaid. As a result of the excellent cooperative relationship between the Department of Public Health and the Department of Social

Services we have developed programs for outreach and streamlined eligibility requirements. The implementation in January of the four-page shortened Medicaid application for pregnant women has resulted in approximately 6,000 more women being added to Medicaid just this year. We are also continuing to provide maternal support services for these children up to two months of age.

While the expanded Medicaid eligibility implemented in Michigan is helping to provide some health care services to a group of people in our society who are uninsured, I am very concerned about some problems which seem to be inherent within the Medicaid program. First, throughout all of our hearings, we heard more and more testimony which demonstrated that physicians throughout Michigan do not participate in the Medicaid program for prenatal care. Throughout the state, women testified to the lack of physicians who would take prenatal care clients, of the need for health-care professionals who deal with high-risk pregnancies, and of the long waiting lists for appointments. For example, in Oakland County of 100 practicing obstetricians, only seven agreed to accept new Medicaid clients. Physicians testified that one reason they do not participate in Medicaid was because the reimbursement rate for prenatal care and delivery is too low. However, Michigan has been raising its reimbursement for prenatal care and delivery services over tha past several years.

The federal government's share in FY 1990 budget was less than the state's share. This year we lost approximately $3.5 million of our federal funds for Medicaid due to a reduction of our federal grant match rate. Without additional federal money for Medicaid, using Medicaid as a means for the uninsured population to gain access to medical care will not work. Physicians either must be required to participate in Medicaid or the reimbursement levels have to be such that physicians will want to participate. Just giving a segment of the uninsured population access to Medicaid is not enough unless there are physicians who will provide the care.

Another problem we identified was the fact that we bring these women and infants into the health care system at some level with the increase in eligibility, but then we drop them from the maternal support services program after the infant is two months old. Where do these children then go for preventative health care, for well-baby care, where does the mother go when she becomes sick? Federal law allows the 100 percent of poverty limit to be used for children under age five. Under OBRA'87, in Michigan we have allowed those children whose income is 185% of the poverty level for children under age one to be eligible for Medicaid.

The access to health care issue is a complex one, but we cannot allow the complexity of the issue to slow us down. Each day babies die due to lack of proper medical care. There is an urgency to the resolution of the access to health care issue. One we must not lose sight of. One which must continuously spur us on. We must be strong leaders in the discussion and formulation of programs and initiatives which address the access to health issue. I look forward to working with you on this issue.

Ms. Alvastine Stewart
24429 Filmore Apt 188
Taylor, MI 48180

June 28, 1989

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, DC 20510

Dear Senator Donald W. Riegle, Jr.:

I am pleased to be here at the hearing this morning. I would like to personally, thank you, for requesting my present to be at such an important hearing on health care for uninsured individuals.

I support your work to ensure adequate funding for federal health programs, including Medicare and Medicaid, and to improve the overall health care system.

As a dietetic intern with the City of Detroit, during my community health center rotations, some young pregnant teenagers are denied WIC (Women, Infants, and Children), a federally funded program for low income families. They are unable to show a proof of income or Medicaid from Social Service.

Recently, I had to refer young pregnant mothers for emergency food because they were unable to apply for WIC.

Senator Riegle, Jr., I have had many experiences during my dietetic internship. There is one particular experience I would like to share with you, it has been the saddest. After providing nutritional counseling to a sixteen - year - old pregnant mother (with her teenage girlfriend for support), who is at the end of her second trimester (greater than twenty weeks), and have gained less than ten pounds. Her nutritional intake, and weight gain is assessed as poor.

She stated, I have moved so many times, here and there; I don't get much to eat or rest, the people I am living with now - my girlfriend's mother don't have much food - milk. My mother is a drug addict and Social Service cut her off the program. I tried to get on at Social Service; they said I wasn't qualified because of my mother.

I would like to suggest, a liaison to your office from people, such as myself, for anyone young or old, male or female; a 1-800 number for assistance for those who do not have health care, so that the overall system can be improved in a shorter period of time.

I will be concluding my internship on August 18, 1989. If I can be of further assistance to you, please do not hesitate to contact me.

Sincerely Yours,

Alvastine Stewart

Ms. Alvastine Stewart
Dietetic Intern

Suburban West Community Center
A non-profit private contract agency funded by the Detroit-Wayne County Community Mental Health Board

June 27, 1989

Honorable Donald W. Riegle, Jr.
State Capitol
Room 705, Washington Square Building
109 W. Michigan Avenue
Lansing, Michigan 48933

Dear Senator Riegle:

Thank you for the opportunity to comment on access to health care for uninsured individuals.

Suburban West Community Center is a community mental health agency serving Northville, Plymouth, Canton, Livonia and Redford Township in western Wayne County. We are a non-profit organization funded primarily by state and county funds. Our clientele are adult mentally ill who for the most part have been hospitalized at least once for a serious psychiatric disability.

About 80% of our clients are indigent. Unfortunately, not all of those are eligible for programs such as Medicaid. As a consequence, while their psychiatric problems are covered by county/state funds, their medical needs are not. Our agency does not receive sufficient funds to meet the variety of medical needs of our clients who are not insured for such procedures as annual physicals, regular laboratory tests, and other exams and treatment necessary for physical problems frequently found in the chronic mentally ill population. We limit use of agency funds for such purposes to emergency situations. Out of a current case load of about 350 clients approximately 100 are not eligible for Medicaid or other types of insurance.

Another need that I see is funds to cover clients who do not meet the acceptability criteria for our county/state programs because they have never been previously hospitalized for a psychiatric problem nor are they considered to be in crisis. While these people are not what you would call "seriously" mentally ill, they do have significant mental problems that interfere with their living productive and satisfactory lives. About 100 out of 150 clients in this category do not have sufficient funds to pay our fees. We have been successful on a limited basis until recently in serving this population through some successful fund raising activities. Budgetary problems forced us to cancel this program, however. We are now attempting to obtain special grants to serve this population.

While we do receive funds to serve the seriously mentally ill population I would be remiss if I did not indicate that the funding is by far inadequate. Caseloads of 100 per therapist are common in community mental health. New funds that are made available are earmarked for new programs. While new programming is needed we also have a need to improve current programming. I am sorry to say that in my opinion community mental health has a long way to go before we achieve a first rate system.

I hope these comments are useful to you. If you would like further information we will try to supply it.

Sincerely,

Thomas W. Herzberg, Ph.D.
Executive Director

June 28, 1989
322 East Fifth Street
Monroe, Michigan 48161

Senator Donald W. Riegle, Jr.
c/o 1850 McNamara Federal Building
477 Michigan Avenue
Detroit, Michigan 48226

Dear Senator Riegle,

I recently received your correspondence about the Senate Finance Subcommittee on Health for Families and the Uninsured. I applaud your interest in and efforts toward availability of health care for all Americans.

As a nurse pursuing graduate studies in public health, as well as one who witnessed firsthand the neglect of the uninsured as well as the abuse of the reimbursement systems of the insured by corporate interests in health care, I am pleased that elected officials such as yourself are aware of the need for reform.

Because I understand how difficult it must be for you to stay abreast of all issues and implications in this important area, I would like to recommend to you two excellent references on the subject. One is an article entitled "How Nurses Would Change U.S. Health Care" by F. L. Huey, published in the American Journal of Nursing, November 1988, pages 1482-93. The other is a book, Rationing Health Care in America--Perceptions and Principles of Justice by Larry R. Churchill, University of Notre Dame Press, Notre Dame, Indiana, 1987.

Thanks and keep up the good work.

Yours truly,

Sally B. Sulfaro

Sally B. Sulfaro, RN, BSN, CEN, CCRN

June 25, 1989

United States Senate
Washington, D.C. 20510

Dear Senator Riegle,

Please see what you can do for health care for all people.

My husband has been disabled for 10 years - all we receive is a Social Security check each month. This is our only income which is not much. I have to pay my own Hospital Insurance, which is almost $400.00 every 2 months. My Husband gets Medicare, but has to pay his own Blue Cross, which is almost $100.00 every 2 months. We are to the point we can't afford more insurance. It has bled us dry. I don't know what to do anymore. My Husband is 51 and I am 49 so we are not old just have poor health. Worry constantly anymore what will happen if I take really sick. I don't understand why individuals can't be put in a group the way employers do. We have to pay full price on prescriptions and do not get anything back. We don't want to go on Welfare for help as we are to proud & have always made it on our own, but now we're to that point where we don't know what to do.

Something should be done to stop raising prices on Health Insurance because it is outrageous. It is time something is done for the individuals health care.

Thank you

Sincerely

Mr. & Mrs. [illegible]

St. Bede

7/9/89

NO HEALTH INSURANCE...

by Fr. Tom

Now I have something to back me up.

U.S. Senator Don Riegle, chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, held a senate subcommittee hearing on "Health Care for the Uninsured" Wednesday, June 28, 1989, at St. John's Armenian Church near Northland.

There are 37 million Americans with no health insurance, the senator points out. Of this 37 million, 12 million are children.

What does that mean locally? In Michigan, there are one million without proper health insurance. Over 300,000 are children. About 49 percent are in southeast Michigan, 350,000 in Wayne County.

Senator Riegle seems to think it is a crime many people do not have health insurance. I have expressed that I felt this is the situation with regard to employees at Beaumont Hospital, and I have received static.

This problem affects people all across our American society. It is not just a poor problem. As the senator emphasizes, this is something that incudes the working and the employed. In many cases, only the worker is insured, not his/her family.

Private health insurance is expensive. Don't expect the average Joe to take out a policy after he has paid his bills. The money isn't there.

The subcommittee is investigating why company rates are high (because they pay for the uninsured) and why hospitals are closing (because they can't provide for the needy). It has talked about "cost shifting" (A bill must be paid and is added to bills of those who do have insurance). And the senator is worried bacause you can only cost shift so long!

At any rate, Riegle wants to bring this to the attention of Congress and the President. Perhaps the nation (you and me) needs to be informed, too, so that we can have a mass movement in the right direction.

What dismays me is that somebody at Beaumont Hospital has complained about my two recent columns on health insurance at that hospital. You remember. I questioned openly why someone would work--of all places--at a hospital for two years and receive no

more..

1989 JUL -5 PM 1:40

health insurance. The columns I felt were specific and to the point. (Note: I emphasize I am not just picking on Beaumont. The United States Post Office is a sinner here. So are many places of employment for various reasons. For example, we at St. Bedes have hired two part time custodians in order to avoid paying benefits to one full time custodian.)

At any rate, who complained? Public Relations at Beaumont for one. The lady wanted to discuss the first article. When I realized she had not read the second piece, I told her I would send it and then to contact me.

In the meantime, Fr. Arnie gets a complaint from a nurse, refering to some of my wording. The word "notorius" stuck in her craw. "Beaumont Hospital is a NOTORIUS abuser..," I said. For pete's sakes, pick on a word and miss the point!

In the first place in the old days, you would call the pastor and he would shut up the assistant pastor. That doesn't work any more.

So okey "notorius" is a bad word. It is not a notorius or known situation. That is the trouble: We do not know about the uninsured.

"Tom" says Fr. Arnie, "be cool. That's my hospital."

"Arnie," I say, "I am not criticizing their work. It is a fabulous place for operations and health care." (God knows, I may have to go to a hospital some day. Now because of this I feel I may have to drop dead to save the hospital the trouble of finishing me off.) "It is health benefits for their employees I am talking about, Arn."

So "notorius" is a bad word? How about secrative, devious. No, those are badder still. They say we don't know about a problem and are trying to cover it up if we do know.

This IS the frightening problem. Beaumont PR and the nurse and all of us may have health insurance. We are not worried about someone who hasn't any health insurance. We should be! This is one problem of our society. Once we have it made (This includes black people), we tend to forget about what is happening below us. It is time to be concerned. I wish Senator Riegle well and and will do whatever we can to promote his program.

In the meantime, Leon, the employee at Beaumont, has been told he may soon be a regular. However, he wonders why someone was recently hired in as a regular while he has worke there two years and still ha a "temporary" status.

That brings me to unions And that is a whole differen bomb!

OF MANY THINGS

by FATHER ARNIE

WHAT A DIFFERENCE A DAY MAKES

Several weeks ago, a number of parishioners (mostly from the Christian Service Commission) spent a good part of Saturday morning and afternoon, weeding, pruning, digging, and planting on the front part of our church property. We are most deeply grateful to Rick & Carol Walter, Vern & Joann Konzal, Bob & Pat Hadden, Larry & Alonda Cousino, Frank & Joann De Santis, Alton & Lenora Kendrick, and Nancy Scott. What a difference a day makes!

I might mention, also, that Father Tom has been seen planting flowers all over our parish property. Thanks, Tom. Just please don't sell them on street corners.

50TH ANNIVERSARY OF ORDINATION

I'll be travelling to St. Clair, MI, this afternoon to celebrate with Father Karl Hubble. It's the 50th Anniversary of his ordination to the Priesthood. Father Hubble is the brother of Ken Hubble, a long time member of our parish. Father Hubble taught me 41 years ago at Sacred Heart Seminary.

I like going back to St. Clair because I still have relatives living there. My parents, of happy memory, were married in St. Mary's church about 59 years ago by Msgr. Krummenaker. Out of curiosity, I looked in the marriage register when I was there last year and noticed that they spelled my mother's maiden name "Snyder" instead of "Schneider." I think I'm still legitimate.

I only have 21 more years, to the day, until I celebrate my 50th, should I live so long.

Addiction

Addiction, Webster tells us, is the compulsive need for habit forming drugs. The idea of addiction was considerably broadened last year with the publication of an anonymously written book: Hope and Recovery, a Twelve Step Guide for Healing from Compulsive Sexual Behavior. The book reminds us that in recent years we have witnessed a growing number of groups focusing on everything from overeating to alcohol as examples of addictive behavior. The book I mentioned deals with the self-distructing life of someone dominated by sexual activity and fantasy. In several hundred pages at the end of the book, various persons detail the history of their own addictive behavior. The pain, alienation and suffering in these accounts is awesome. Even more awesome is the way these people have tried to deal with their problems and bring some order into their lives.

Following the famous Twelve Steps of Alcoholics Anonymous, these men and women have deepened their appreciation of spirituality as a way of structuring their lives, of responding to the demands of their own inferiority. As a result there has been a conscious reclaiming of the dignity and purpose of their lives. As they respond in this way to God's love, they find themselves empowered to become more loving, more Godlike. They come to realize that compulsive behavior represents a great deal of energy that is misdirected, energy that is unconsciously employed to deter them from hearing and responding to God's summons to respond to his love.

It is easy to talk about addiction as though it were something other people suffer from. Perhaps it's time for the rest of us to probe the lack of freedom in our own lives, our own compulsive behavior. It is often said of addicts that they are the last to know of their addiction. This may be the case with our society in general. Living as we do in a consumer society, are we unable to see our own addictive attitudes to goods and possessions and profits? Must we simply have the latest, the best and the most, regardless of what our attitude does to ourselves and others? Has it deafened us to the voice of the Lord: Come, follow me!

There is nothing wrong with having or wanting things–they are the goods God has given us–just as there is nothing wrong with sexuality or alcohol or eating in themselves. But when we are so possessed by our need for something that we can justify almost any type of behavior, it is time to recognize it as an addiction.

We are, all of us, united in our dignity, our sinfulness and our need for redemption, in the call to respond to God's love and grace. With God's help, we can focus our lives, so that gradually the choices we make proclaim us as a people called by God to make his presence more tangible in our world. – Androgogy

Interested in Learning More?

On Monday, June 5th we will be starting a new phase of our RCIA program.

Please note,meeting is Monday June 5th ,not 6th as listed previously.

We plan to meet with our candidates for reception into the Catholic Church and their sponsors each Monday evening to study and discuss the readings of the previous Sunday.

We would like to invite anyone who is interested in learning more about the scriptures and the Catholic Doctrine which flows from them to join us any Monday evening at 7:30 p.m. in the parish office. It's not necessary to 'sign up' or even make a commitment to attend every session. Just join us when you can. Your presence and your input to our discussion will be most welcome.

Golf Outing Set

Men of St. Bede are urged to set aside **Thursday, July 20th at Noon** for a day of fun and camaraderie on the links of Woodland Golf Club.

For $16 you can enjoy a round of golf with fellow "pros" and duffers, both of whom have a chance for numerous prizes at the end of the day.

To reserve a tee off time, please call:

Chuck Donelson	559-2415
Don Powers	646-0052
Bill Keefer	642-1258

1980's: The 80's Decade of the Family

The centurion in the gospel asked Jesus to heal his servant. All of us experience the need for healing in our lives. If your marriage needs healing, consider a Look Again Weekend. If you have lost a spouse through death or divorce, consider a Beginning Experience Weekend. For more information, call 237-5892. Be like the centurion and ask Jesus for help.

A National Disgrace...

by Fr. Tom

I may be shooting from the hip.

After all, the primary rule is to get all the facts before you speak. On the other hand, if you recognize an abuse, state the problem and see if others can add to your observations. I see an abuse in our society—a national disgrace—regarding health insurance for senior citizens and for young marrieds.

As a priest of the Archdiocese of Detroit, I have good health insurance. There are those over us who have met the problem and have seen to the proper program. I trust them. If I get sick, I should have no worries about how to pay the bill. I guess in ordinary jargon that means we have a good union.

Never having worried about these things, it is an eye-opener to realize some people don't have these things. It seems that many people in our society today are being screwed. (Pardon me, Ann Landers and Miss Manners.) My thesis is there is a problem here about health insurance that has reached alarming proportions. There are people who are not covered and nobody is doing anything about it.

Leon, for instance (not his real name), has been working at Beaumont Hospital for almost two years. He is twenty-nine, married; there is one child. He receives a wage (that's another column), but no other benefits. After three months or ninety days, he should have received some benefits. At any rate, I quizzed him the other day about his work at the hospital and why he does not receive any health benefits at the hospital (never mind retirement yet).

"Your wife has said she has to see a doctor," I say as an opener. "She hasn't been to one since the birth of the baby several months ago and there are some problems."

"I don't got no health insurance," says Leon. "I should of looked into it, but I don't know what to do."

"You have worked hard and long hours since being employed there. What is your status?'

"'I am a regular, whatever that means," replies Leon. "I was a contingent for awhile, but they like my work and told me I am a regular employee.. Now they tell me I have to account for the past two years with them before I can get insurance.

From the sound of things, Leon likes his work and is making this job a permanent commitment. But he needs to get organized and the company isn't going to help him. Like the average person, he is glad to pay the rent, the car, the furniture and have some food. But barely! he would not have given health insurance a thought except his wife keeps bugging him and I mentioned it.

Beaumont Hospital is a notorius abuser of people and people's rights. To be true, however, it is not the only business that uses and abuses its fellow man. It seems to be a policy of conservative politics and big business to ignore the needs of the worker. Washington seems unaware purposely. Canada, by contrast, has a health insurance program worth looking into.

And younger marrieds are not alone. Stan, another friend of mine, had worked at Bill Lee Olds and Jim Carney Buick for years as service manager. He raised nine kids and finally was forced into retirement when the dealership was sold. At what a cost.

Upon retirement, Stan realized he had no retirement benefits and no health insurance. His life insurance was cancelled. He was let go to live on Social Security from which he had to pay health insurance.

He joined the Blue Cross Health Care Network (HMO) because it sounded good. He was refused the group rate. It cost $170 a month from his Social Security. Recently it has jumped to $303 a month because of his age and his wife's age.

You get it at either end from business. When you are young, you give your body and spirit. Too old, you are cast aside, body broken and spirit crushed. Something is rotten in Denmark. Something is dirty in Detroit. Something is amiss in America!

But then I may be shooting from the hip. Justice. Injustice. Revolution. Terror. Mayhem. Not yet. Get the facts first, Thomas.

Does this mean I have to hear more horror stories than the two I have related? I wonder who "they" are at Beaumont, i.e., the Board of Trustees. This may be a commitment that may take me the rest of my priesthood.

Anyway, it is a national disgrace!

A Journey In Faith......

Religious Education Notes.

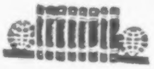
"Something for everyone" was the theme that emerged from the adult enrichment committee planning meeting. The persons on the committee hope to offer the following opportunities for spiritual enrichment for adults: Scripture (a top vote-getter), A Day of Reflection, What Catholics Believe, and recruitment for both a women's and men's retreat. The menu sounds quite appealing. If you would be interested in helping on any of these proposed programs, please contact Maureen or Leo Clement, co-chairs of the adult enrichment committee.

I have received many parent evaluations of the First Communion program. I wish to thank those parents who returned them. All of us who are involved in the First Communion program will consider your feed-back as we evaluate this year and plan for the next. Parental involvement in the preparation of their children for the Sacraments is extremely important. "Parents are first and foremost catechists of their children. They catechize informally but powerfully by example and instruction."

National Catechetical Directory, #212.

Thank you, parents, for the time and effort that you have invested in sharing your faith with your children. Faith is a precious gift that needs to be nurtured and nourished throughout our life-long journey (of faith).

Peace and joy,
Betty Rabaut.



Adult Books Librarian Needed

We are in need of someone to catalogue and keep track of the books in the adult lending library which is located near the Baptismal Font in church. Celeste Caleel has been in charge of this activity for the past two years. We appreciate the time and effort that you have expended on this activity, Celeste. If anyone is interested in taking over this worthwhile project, please call Betty Rabaut at 559-0578.

OF MANY THINGS
by FATHER ARNIE

What's on the Mind of 5th Graders?

I was invited to speak to the 5th grade recently. Before my visit, each of the students wrote down questions they wanted me to address. They were very interesting. I won't give my responses to these questions because we don't have the space to do so. However, I thought you would like to read some of the questions they had on their minds.

1. Did you ever feel like getting married and raising a family? Why can't you get married? Do you ever get lonely?
2. What made you decide to become a priest? How old were you? My mother wants me to become a priest.
3. If a person goes to a priest school (seminary), can he get out if he wants to?
4. How come women can't become priests?
5. Do you ever get nervous when you get up in front of a lot of people, like at a funeral?
6. Do you feel good after and when you visit the sick?
7. What's it like to give a dying person the last rites (Sacrament of the sick)?
8. Do you ever feel like staying in bed and not going to church?
9. Would you still go to church if you weren't a priest?
10. How many times a day do you pray?
11. Why do they call Good Friday good on the day Jesus died?
12. How come a Protestant can't take Communion in the Catholic Church?
13. How was God made? What if Adam and Eve didn't sin? If we were started by Adam and Eve, we're all brothers and sisters.

Unnoticed

There are a number of people who do things for the parish and go unnoticed. That's the way they want it. At times, however, it's good for them to receive some recognition. One of these parishioners is Tony C. (Chludzinski).

Tony C, for some time now, has planted flowers on the parish grounds, and waters them regularly.

Tony C also counts the church collection each week, along with Bernie & Chuck Jones, Steve Gray, Norm Bartelmay and Ralph Stepaniak. Thanks, men!

Liberty and Equality

So often one hears the description of the American dream: Liberty and equality for all. It's easy to overlook the fact that these two realities are not twins, they are opposites. And one of the abiding moral challenges for Christians is resolving the claims of each other.

Liberty is clearly a good. Human beings have a dignity that is intrinsic. They do not get their value from their productivity or their usefulness to others. They get their value from their being, from the fact that they are creatures of God, "endowed," as the Declaration of Independence says, "with certain inalienable rights." Indeed, liberty is listed as one of those rights.

The problem, though, is that unfettered liberty leads to inequality. After all, we are not all equal to start with. Those with more money, more talent, more time or space, they are more free. And a system that holds liberty as the highest value, at least if liberty is understood as "starting now," will inevitably increase the situation of inequality bit by bit.

That is a sad truth. Indeed, it is a proof for the doctrine of original sin: That things in this world are not precisely as God intends them.

For equality is a value, too. Since all persons have a radically identical dignity, it is right that all should be treated equally in fundamental respects. That very same Declaration of Independence says that all "are created equal, endowed with inalienable rights."

But any system built on a rock-bottom commitment to equality will surely find itself required to limit liberty. Tax structures will be progressive, taking form the rich to benefit the poor. Non-discrimination will yield to affirmative action, attempting to remedy the injustices of the past and to put in place an increasingly complete structure of equality.

And that, too, in the end, is a proof for the existence of original sin. Why should the crimes of the father be visited upon the son? Why should discrimination be the cure for discrimination?

It is very mysterious. But two points are clear. First, the honest person will avoid a facile pairing of liberty and equality, as if there was no cost involved in implementing them. And second, while the Christian challenge of love can never ignore either liberty or equality, that challenge will most powerfully manifest itself in the attempt to maintain the tension between them.

For if we completely lose either, we will have lost the Christian vision of the person.

Androgogy

Garage Pre-Sale for Parishioners

Friday, June 23rd
7:30 to 9:30 p.m.

The Men's Club is hosting a Parishioner's Night before the 2nd Annual Garage Sale. For a 25% markup (over already low, low prices), our parishioners have first choice at the many wonderful items that have been donated.

We invite you to come and browse. Come to visit or come for the refreshments. See you there!

Garage Sale Hours for the Public

Saturday, June 24th from 9:00 a.m. to 4:00 p.m.

Sunday, June 25 from 12:00 p.m. to 4:00 p.m.

N.B. Donors: Pick-ups or drop-offs can still be arranged by calling 557-3852.

Friday Mass Reverts to 8:30 a.m.

Daily Mass attendees are reminded that during the summer, Friday Masses are at 8:30 a.m. (not 9:15 a.m. as during the school year).

Daily Masses are now at 8:30 a.m. Monday thru Saturday.

The word "listen" contains the same letter as the word "silent."

Gossip

by Fr. Tom

"Kyle? This is Fr. Tom. I just talked to one of your hospital gossips and he has the whole story screwed up."

I am on the telephone to a friend employed at Beaumont Hospital. You remember last week I told you the story of Leon and his lack of medical insurance from the hospital.

Leon had been working at Beaumont for almost two years. He is married, twenty-nine with one child. His wife has been after him about medical insurance and so have I. He had been told he would receive it, but he was confused about his status. He is happy to have a job, but doesn't realize his employer has some obligations.

Anyway, I called someone at Beaumont, surly, and related the story to her. It was a private discussion -- or so I thought. In our discussion, I pointed out that Leon had worked over the recent holiday because he needed the money. Remember, one two-week paycheck a month goes for the rent. With a baby and bills, you try to put in all the extra time you can.

"Kyle," I say, "the story I heard from one of the gossips is that Leon was forced to work the holiday. That is nonsense! He was elated to work for the extra money. The problem was the medical insurance. (By the way, the worse gossips are men. Or maybe they are the best. They can embellish a fact until it becomes the scariest fiction.)

I go on to tell Kyle the issue again is medical insurance. Leon hasn't got any even though he has worked in the hospital for two years. It seems to me an injustice. That is why I called on my own and complained.

Between the time I had written the first article and it appeared in the paper, a week had gone by. When you read this, another week will have gone by. In the first week, I had decided to see a hospital person (a supervisor, hatchet person, hit man, public relations guru, personnel person), but never got around to it for obvious reasons. I did call some employees, including my friend, Surly.

Along the way, I gathered some factual information. Remember I had been shooting from the hip. I was not using a six shooter, but a sawed-off shotgun that scatters pellets and breaks windows. This is some of the stuff I found out:

Beaumont apparently needs a union bad. The employees there are cutthroat crazy. You want to step up the ladder, you just cut down the turkey in front of you. Believe me, there is a lot of stepping up. But the Board of Directors (excuse me, "they") apparently kinda like it that way.

At any rate, if you are unfortunate enough to be employed at Beaumont, you think this may be the beginning of a steady job. But there is none of that 90 day stuff like the old days. Maybe it was Reagan's program of union busting like he did with the airline controllers. Maybe it is the conservative mind which thinks it is every person for him/her self. When I was 18 (about 1949), I worked a summer in a small factory. After being a spot welder for 90 days, I came under full benefits and became a member of the union. None of that today.

They do not do that at Beaumont or a lot of other places. They don't have unions. Management uses a technique called (for want of a better name) "people control". It puts one employee against another as they step up the ladder. On each step you kick off as many people as you can to make room for yourself. It is all very unchristian, but who cares as long as you go up?

So anyway, at Beaumont you get employed and become a "contingent". A contingent is someone who is employed for 89 days, although there are some contingents who have worked there for two years or more. Remember, there is no union.

Next step up is to be promoted to "temporary". A temporary is ... well, it is kind of vague. A temporary, however, gets no benefits, health insurance. Again, this is another on-going process. And, by the way, you are not yet on the ladder.

Along the way you are told by someone on the ladder you might become a regular. You get letters from supervisors, directors of departments - all kinds of ladder people — praising your work. Pretty soon, it is gonna happen, they tell you.

This is where I had talked to Leon at the request of his wife. Remember, he had been working his heart out for two years and I began to ask questions that turned into gossip that turned into detraction.

So here we are: 90 days were up almost two years ago. Leon has a baby. (Well, actually his wife had the baby although Leon's time at Beaumont has been sort of a rape and he goes through the process of pregnancy. So maybe he is having a baby figuratively.) He still has no medical insurance. No benefits. No security. No peace of mind. Just the turmoil of explaining to a ladder person that he needs some help. Then I learn about it and shoot from the hip.

Where was I? Oh, yea, it is time to bring back the union. Not just at Beaumont, but at a lot of other places. Guys like Leon gotta get saved before they go down the tube. First, we have to instruct them that they have some rights. Then, we have to convince the government we are not upsetting the American way of big business. Then we have to convince "they" at Beaumont that there employment policy is the pits. But in the process, we have to keep Leon from losing his job.

Remind me not to confide in anybody again.

-30-

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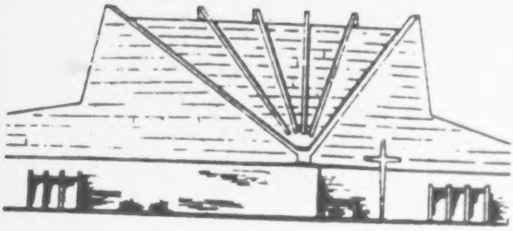
To reserve a tee off time, please call:

Chuck Donelson	559-2415
Don Powers	646-0052
Bill Keefer	642-1258

Paper Drive This Weekend

Sunday, June 11th.
from 9:00 am-1:00 pm

Please bring newspapers only; do not put them in plastic bags. Rather tie them or slide them into paper bags. Leave papers at truck only when helpers are there during listed hours above. Your participation is greatly appreciated. This will be the last drive until the Fall.



CHURCH OF
ST. BEDE

26 June 1988

RE: Your talk Wed., June 28

Dear Senator:

Don't forget the young employed at such places as Beaumont Hospital. I hope to be present at your hearing and will encourage others to attend.

Respectfully,

TP

Rev. Thomas R. Physician

MY SON IS 26 YEARS OLD, MARRIED AND THE FATHER OF A NINE MONTH OLD SON. HE IS EMPLOYED AS A FINISH CARPENTER AND MAKES IN THE AREA OF $30,000 PER YEAR. HIS EMPLOYER PROVIDES NO BENEFITS. HEALTH CARE COSTS FOR THIS FAMILY ARE SO HIGH THAT THEY HAVE A HARD TIME MAKING ENDS MEET, BUT HIS SALARY IS SO HIGH THAT HE WOULD NOT QUALIFY FOR ANY ASSISTANCE. HIS HEALTH CARE WHICH COSTS AROUND $250 PER MONTH ONLY PROVIDES FOR INPATIENT CARE, AND YET HE CANNOT AFFORD TO BE WITHOUT IT, AS HE HAS A CHRONIC HEALTH PROBLEM.

MY SON & 19 OF HIS CO-WORKERS APPROACHED THE OWNER OF THE BUSINESS AND ASKED HIM TO REGISTER THEM AS A GROUP, THUS BRINGING DOWN THE PREMIUM PAYMENT. THE OWNER REFUSED.

I BELIEVE THAT COMPANY OWNERS WITH MORE THAN 20 EMPLOYEES SHOULD BE REQUIRED TO PROVIDE HEALTH CARE AND BENEFITS FOR EMPLOYEES.

Mrs. L. J. Taminski
3041 HARTFORD LANE
ROCHESTER MI 48064

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Gerald Terlep, PhD

Address Bon Secours Hospital, Medical Education, 468 Cadieux Road, Grosse Pte. MI 48230 # 313-343-1490

Representing : Bon Secours Hospital Medical Education and HANAI program.

****

I invite you to attach a prepared statement or to submit your written testimony:

Bon Secours Hospital and the American Indian Family Service (A.I.F.S.) have prepared a program to allow access of urban Indian poor to Family Practice Centers throughout Southeast Michigan. The program is called Health Access for Native American Indians (H.A.N.A.I.). Robert Wood Johnson Foundation has a pending request before it by HANAI for a three year grant.

HANAI enrolls members of its five American Indian Social Centers directly into nine cooperating general hospitals and their Family Practice Centers. The hospitals set a "reduced fee program" for HANAI. HANAI expects to serve about 1,000 families who are American Indians who are poor in urban SE Mich.

I will send a detailed memo on HANAI for the subcommittee's consideration.

Gerald Terlep PhD/Director of Behavioral Science

The University of Michigan

SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF EPIDEMIOLOGY

109 OBSERVATORY STREET
ANN ARBOR MICHIGAN 48109

June 20, 1989

Senator Donald W. Reigle
109 West Michigan Ave.
Suite 705
Lansing, Michigan 48933

Dear Senator,

Senate Finance Subcommittee on Health Hearing

The enclosure is a paper presented to the Michigan Academy of Science Literature and the Arts at Grand Rapids earlier this year. As you will see from the abstract only three quarters of diabetic and hypertensive patients entering the life-threatening and exceptionally expensive condition of end-stage renal disease (ESRD),which requires either transplant or life time thrice weekly hemodialysis for survival, had access to medical care. As might be expected twice as many blacks had no medical coverage and for non-medicare insurance less than two thirds of blacks compare with four fifths of whites, were covered. There was absence of non-medicare insurance coverage in nearly a third of ESRD patients between 19 and 40 years of age.

Our hypothesis is that the provision of Medicare coverage after ESRD may be more expensive than providing access the medical care for the early diagnosis and more intensive preventive treatment of diabetes and hypertension as the precursors of half of all cases of ESRD.

The Director General of WHO, Dr. Hiroshi Nakajima's statement on the inside leaf of the enclosed paper would seem particularly appropriate to bring to the attention of each member of your committee.

Please accept my apologies for not being able to be present in person at this important hearing.

Best wishes.

Yours sincerely,

Victor M. Hawthorne MD

Victor M. Hawthorne, M.D.
Professor of Epidemiology

cc: Jacqueline David
Sanford Izenson
Sandra Peckens

enclosure

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permission

permission
Granted
Victor M Hawthorne
June 28, 89

Access to Medical Care in End-Stage Renal Disease

Medical Science Section

Victor M. Hawthorne, Mara Julius,
Jill D. Kneisley, Patricia Carpentier-Alting,
O. Lynn Deniston, Robert A. Wolfe, Friedrich K. Port
University of Michigan, Depts. of Epidemiology,
Public Health Policy and Administration,
Biostatistics, and Internal Medicine,
Ann Arbor, Michigan 48109-2029

Dr. Hiroshi Nakajima
Director General of WHO:

> "What is needed is a reassignment of national and international priorities - a restructuring of international conscience accompanied by a redistribution of resources."
>
> World Conference on Medical Education, Edinburgh. Lancet, II:462, 1988.

Abstract

Responses to questions administered at interview to 989 patients with end-stage renal disease (ESRD) regarding insurance coverage indicated absence of non-Medicare insurance coverage in 27 percent and 23 percent of patients whose reported cause of ESRD was hypertension and diabetes respectively. Twice as many blacks as whites reported no Medicare coverage; and for non-Medicare insurance, only 61.2 percent of black patients, compared with 86.8 percent of white patients, were covered. There was absence of non-Medicare insurance coverage in nearly a third of ESRD patients between 19 and 40 years of age.

These findings are of relevance to current interest in preventing progress to nephropathy and ESRD through earlier detection and better control of hypertension and diabetes. Medicare coverage after the onset of ESRD may be more costly than removing barriers to access to medical care by providing early coverage for treatment and preventive purposes.

Access to Medical Care and End-Stage Renal Disease

Current estimates of numbers of patients without access to medical care are set at 40 million for the nation of whom between a million and a million and a half probably reside in Michigan. A Robert Wood Johnson Foundation report of 1986 put the proportions of uninsured blacks at 10 percent and Hispanics at 20 percent - compared with 7.5 percent of non-Hispanic whites; and noted that twice as many uninsured as insured had no regular source of medical care [1]. In Michigan, the League for Human Services found 10.9 percent of all races - 10.5 percent white and 11.4 percent black - uninsured [2]. In 1988 the Michigan Department of Public Health highlighted ability to pay for health services as one of the most important factors governing their use [3]. The same view was endorsed by members of the Michigan Public Health Association at their 1988 annual conference [4]. Clearly the question of access to medical care had emerged as a major issue at a propitious time for public debate.

Independent facts and arguments to support change in public attitude are notoriously difficult to acquire, particularly in the field of public health and prevention where the predictors of life-threatening events may precede their advent by many years; and possibilities of prevention tend to be overshadowed by the success and drama of technological advances. One condition with emerging potential for prevention [5] is End-Stage Renal Disease (ESRD); a terminal condition until 1960 when clinical nephrology transformed the therapeutic situation with the introduction of chronic hemodialysis. The need for open access to treatment for ESRD was recognized in 1973 when ESRD patients became eligible for Medicare. Within the space of a few years 0.4 percent of Medicare beneficiaries with ESRD were consuming upward of 10 percent of Medicare benefits.

The health information system that has now evolved into the U.S. Renal Data System (RDS) had its origin in organizations like the Michigan Kidney Registry (MKR). Established in 1969 the registry has complete records collected on an obligatory basis from 1973 to the present on all Michigan ESRD patients. By 1984 the registry had grown to 7,000 patients [6] and by 1987 to 12,500, 4,800 of whom were still alive [7]. In 1981 physician-reported causes of ESRD in the Michigan Kidney Registry were diabetes mellitus (24.5%), hypertension (24.2%) and glomerulonephritis (20.9%) with blacks having relative risks of 3.8 for diabetes mellitus, 10.9 for hypertension and 1.7 for glomerulonephritis [6]. In 1983 the Health Care Financing Administration commissioned a new five-year study of the relative effectiveness and cost of transplantation and dialysis in ESRD based on the MKR. Complementing the review of cost and survival was a study of quality of life which also assessed other aspects of the patients, including the three questions which addressed insurance coverage. Answers to these questions now provide information on sources of payment for medical care, but not particularly to access to preventive measures in the early stages of the disease process.

Material and Methods

The Michigan ESRD study sample included all patients aged 18 years or more residing in Michigan with onset of ESRD between 1981 and 1985 who six months after onset of ESRD were receiving continuous ambulatory peritoneal dialysis (CAPD), had received a living related donor transplant or had received or were waiting for a cadaver transplant together with a random sample of those receiving in-center hemodialysis at that time. The general response rate in the quality of life study was nearly 90 percent.

Data were collected by personal interview at sites of the respondent's choice. Nearly half of the in-center hemodialysis patients elected to be interviewed during dialysis while most other interviews were conducted in the patient's home [8]. The "insurance" questions asked were the following:

F1. Next, I would like to ask you a few questions about who pays for your medical expenses. Do you qualify for Medicare benefits under the kidney program? Yes/No

F2. Do you have any hospital or medical insurance that pays any part of hospital or doctor bills? (Include membership in health care plans but not accident insurance or sickness income insurance.) Yes/No

F3. How much is the total cost to you and/or your immediate family of your medical and doctor expenses? (This would include payment for prescription and non-prescription drugs, out-patient charges, doctor bills, anything of this order that is not covered by insurance or Medicare.) (THIS MAY BE DIFFICULT FOR R TO CALCULATE BUT PERSEVERE. BE SURE YOU ENTER THE DOLLAR AMOUNT IN THE CORRECT PLACE.) What is the dollar amount for you per year for medical expenses? $ __________ per month, or $ __________ per year, or $ __________ other (specify).

Results

Nine hundred and seventy responded to question F1, 981 question F2 and 865 question F3. In response to F1, 93.7 percent of the patients reported that they qualified for Medicare (6.3% did not qualify). In response to F2, 79.6 percent stated that they had hospital or medical insurance, leaving 20.4 percent without insurance other than Medicare. Only 22 patients (2.2%) had neither Medicare nor other insurance. Total amounts of self-reported medical and doctor expenses ranged from $0 - $36,000/year (mean = $1,072.26 and sd = $2,307.79), 14.5 percent reported that they had no out of pocket expenses.

Medicare and insurance coverage by primary cause of ESRD is summarized in Table 1. ESRD patients with glomerulonephritis as the primary cause of ESRD were most likely to have Medicare coverage and also to have insurance coverage and patients with hypertension as the primary cause of ESRD least likely. Medicare coverage was nearly equal to that for glomerulonephritis in diabetics who occupied a similar middle ranking between glomerulonephritis and hypertension for insurance cover.

Differences in Medicare and insurance coverage by demographics:

Although patients covered by Medicare did not differ by age or sex, there was a racial difference between 95.0 percent of white patients covered vs. only 90.2 percent of black patients ($p < 0.01$). While there were no differences in other insurance coverage by sex, blacks were less likely to have other insurance than whites (61.2% vs. 86.8%, respectively, $p < 0.001$), and younger patients were less likely to have other insurance than those in the older age groups (71.7% of those 19-40 had other insurance vs. 84.0% of those 41-60 and 83.7% of those 61-90, ($p < 0.001$).

Differences in Medicare and insurance coverage by primary cause of ESRD for each demographic category:

Further study of Medicare coverage by primary cause for each demographic category showed no significant differences between diabetes, glomerulonephritis, hypertension, or for other causes when males, females, blacks, whites, and age breakdowns were analyzed separately. When insurance coverage was analyzed in this way, only one age group showed a significant difference between groups. Among 41-60 year olds, only 67.7 percent of those with hypertension as the primary cause of ESRD had insurance coverage, which is significantly lower ($p < 0.001$) than the percentages for diabetes (82.0%), glomerulonephritis (90.4%), and other causes (88.9%).

As Medicare coverage extends only for a limited time period among successful transplant patients, Medicare coverage was re-analyzed excluding patients with transplant for three years or more. This reduced the numbers in the sample from 989 to 954 but the results were no different.

Discussion

Excluding Medicare and accepting a degree of variation in patient interpretation of question F2, the findings suggest a deficiency in non-Medicare insurance coverage in the order of 27 percent and 23 percent in hypertension and diabetes groups, respectively, as compared to a significantly lower 15.8 - 17.2 percent deficiency among the other ESRD patient groups. While it might be expected that Medicare coverage would extend to all ESRD patients the magnitude of these levels calls for further investigation of their nature: patients with private means, ignorance of eligibility (14 respondents did not know if they qualified for Medicare), rejection, non-application and the like. The observation that twice as many blacks as whites did not report Medicare coverage hints at the true nature of the underlying problem. Here again, the black/white difference in non-Medicare insurance of 61.2 percent compared with 86.8 percent respectively, could be an observation of more than statistical significance as is the nearly 30 percent deficiency in non-Medicare insurance coverage in those between 19 and 40 years of age. As far as representativeness of the findings is concerned, the quality of life study over-sampled for transplant patients. This and other factors involved in the sampling design, support the need for further study based on a more generalized sample.

Hypertension has long been recognized with diabetes as predisposing to ESRD and to incapacitating or life-threatening complications like retinopathy, neuropathy and coronary heart disease [9,10]. There are now well established guidelines for the management of hypertension; and these are based on the expectation that effective treatment can lower risk of morbidity and reduce fatal outcomes [11]. Likewise the more rigorous control of hypertension in diabetes offers prospects of delaying and reducing the risks of a wide range of complications including ESRD [12] which is the probable outcome in nearly a third of diabetics [13]. Recently attention has been directed to the need for earlier detection of diabetic and hypertensive patients at high risk of developing ESRD [10]. Screening holds promise of adding a further five to ten years to the current lead time through the use of more sensitive methods of detecting albumen in the urine [14]. The validity and methodology of the earlier detection of high risk awaits further study [15]. In the meantime, there's a strong implication that lack of access to medical care may have inhibited earlier detection, lack of earlier treatment could have contributed to the serious and costly outcome of ESRD. The burden of inadequate coverage would seem to fall most heavily on blacks and on the younger ages of all races.

Taken in consideration with findings from other independent studies [16] these findings add a small but significant increment to evidence now accumulating of the need for providing adequate access to health care including early detection and prevention.

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Table 1

Percent distribution of end-stage renal disease patients, by primary cause of ESRD and Medicare and non-Medicare insurance coverage:
Michigan ESRD study, 1984-1987

	Diabetes	Glomerulonephritis	Hypertension	Other
	%	%	%	%
Percent of patients covered by Medicare insurance	94.3	95.6	91.5	92.7
Percent of patients covered by non-Medicare insurance*	77.0	84.2	73.0	82.8

* p < .01

United States Senate

WASHINGTON, DC 20510

HEARING ON HEALTH CARE FOR THE UNINSURED

Senate Finance Subcommittee on Health

Chairman Donald W. Riegle, Jr.

Sign In:
Name: Mr. Tidra Tigner

Address 1101 Monroe
Ypsilanti, MI 48197 (313) 485-2451

Representing :

****

I invite you to attach a prepared statement or to submit your written testimony:

I am 23 years old, currently unemployed, and am on general assistance. I live with my mother, who works part time and has no health care insurance at the present time. In my current situation, I have a rare respitory disease which I have been treated for at the U of M Hospital. The doctors there say that they've only seen three cases like this before, one of which was fatal. In addition, they have told me that it could possibly become cancerous. So far, I have had two operations at the University of Michigan hospital (1986 & March 1987), at which time the polyps in my sinuses were removed. As far as my insurance goes, it was taken away by the Department of Social Services because I could not attend their MOST classes as I was attending Washtenaw Community College. In the fall, I will return to Washtenaw Community College, but as of right now I have over $5000 accumulated in bills and am not in a position to pay them without insurance. As far as my medical condition, the doctors at U of M say I need more tests, but wont take them without insurance.

6/22/89

Dear Senator Riegle,

I am sorry I can not attend the hearing Wednesday the 28th because of an out of town Commitment. I am very concerned about a health insurance plan. My husband and I are both retired, but our health insurance premiums are $372.26 per month plus $31.90 is taken from my husbands social security check each month. I am 63 years old and have to carry an individual policy. It has been very difficult to make payments each month. We spent 2 days last week checking both policies and found out we can NOT drop any policy because of my age and his deductible - I certainly would like to see a National Health plan such as Canada has - I will be following any decisions made by The Senate Finance Subcommittee on Health - THANK you for your concern -

Theresa Tomaszewski
Lapeer, Mi 48446

Tri-County
Dental Health Council
16310 W. 12 Mile • Suite 210
Southfield, MI 48076-2924
(313) 559-7767

June 28, 1989

The Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C., 20510

Dear Senator Riegle, Jr.:

The Tri-County Dental Health Council's mission is to serve the residents of Wayne, Oakland, and Macomb Counties by providing increased access to dental care and by promoting oral health education to the community.

The Council serves low income individuals as a source of referrals to dentists who accept Medicaid and General Assistance reimbursement, and to public clinics that provide dental care at reduced fees.

As government funding has become more limited, public health facilities and clinics that care for low income persons have been forced to discontinue dental services. At the present time, it is almost impossible to obtain low cost dental care in Wayne County for persons who are over the age of eighteen, and sources of low cost dental care in Macomb and Oakland Counties are very limited.

Dental health is integral to total health and well-being. The most fundamental processes such as basic vitamin utilization are hampered when food cannot be chewed properly, and persons with oral infections are not only subject to severe pain, they may be at risk for life-threatening infections such as bacterial endocarditis.

The availability of low cost dental care must be included when considering access to health care for uninsured and low income individuals.

Thank you.

[illegible]ly,

Donnie Snider, R.DH.

Donnie Snider, R.D.H.
Program Coordinator

Your Torch Drive Agency for Dental Health

4085 Mitchell Drive
Flint,Mi. 48506-2055
Monday June 19th,1989.

Dear Senator Riegle,

I am writing to you in reference to concerns for those Americans without access to health care because of a lack of insurance. A very large segment of our american population is the "working poor", who not only earn a minimum wage, but have no basic fringe benefits such as health care. We may need to look at a national health care system like that available in Canada in order to insure that all of our peoples have access to acute and chronic disease health care services. The New England Journal of Medicine, January 12, 1989 had a poignant article prepared by a group of physicans, who feel something must be done and done soon.

Last summer my 25 year old son, who had a minimum wage/ no benefit job, was checking his automobile engine at a local service station when his battery exploded. The debris cut his face and the acid splashed over his upper body. A township police cruiser had just pulled into the station and the officer volunteered to take him to a local hospital emergency room. My son's response was, "No, I have no insurance and can't afford it". He knew enough to flush his eyes with clean tap water and only suffered mild eye irritation. My son is not unique, there is a large number of young people, young parents and old persons out there with no health care safety net.

Over the past four years I have had the privilage of serving the Michigan Department of Public Health through membership on the Chronic Disease Advisory Committee (CDAC). This group brings together health care providers, health care educators, public and private health organization representatives and consumer advocates. Unanimously, the CDAC membership has expressed serious concerns about the inadequacy of health care for those without insurance coverage. How can our nation spend billions on defense, send billions around the world in foreign aid and yet leave many of its own citizenry without the basic human need of health care?

Our nation must be compassionate and caring when it comes to basic health care for its people.

Sincerely,

Darlyne A. Underhill

Darlyne A. Underhill, RDH, Ph.D.

Senator Donald W. Riegle, Jr.
Senate Finance Subcommittee on Health

June 28, 1989

The Hon. Senator Riegle and subcommittee members:

The Lincoln Park Adolescent Health Advisory Committee is interested in the health of our young people and their ability to obtain health care. We wish to inform you of the needs of this community, and encourage you to continue your efforts to make funding available for services that address the health needs of adolescents and families, especially where no such services exist, and for those who lack insurance and adequate income to pay for their health care.

This community's population is composed of predominately white, working class people, shifting to younger couples with young children. According to 1988 MESC statistics, unemployment for the area is 8.4%.

Through a grant funded by the State of Michigan Department of Public Health, we have been able to assess the health needs of the adolescents in this community and plan ways to begin to address these needs.

In a survey we conducted earlier this year, we discovered that most of our adolescents(7th-12th graders), can afford health care. However, **12%** said that they lack money to go to a doctor, and **11%** said that they have no professional medical person to go to when they are sick. **11%** reported that they have not received medical care for **3-4 years or more** (with **1%** saying they have **never** received medical care). **28%** of the students reported that they have not seen a dentist in a **year or more** (with **2%** having **never** seen a dentist). Lack of transportation was indicated as a reason for not being able to receive medical services by **9%** of the students surveyed.

Our parent survey (38% return of 381 mailed surveys), showed that most families have health insurance. However, **21%** reported having no health insurance, paying for medical care themselves,(not Medicaid recepients). **6%** receive Medicaid benefits. Also, **5%** of the parents reported that they receive medical services from a hospital emergency room, and **2%** have no regular source of medical care. **4%** reported having no dental care for their adolescents. **8%** said that there were times when they did not take their child to a doctor when the child needed to go, because they lacked the money.

The availability of free or low fee medical services in this area is limited. Adolescents have access to a state-funded adolescent health clinic in a neighboring community. The local health department is also available for some health services and is located in neighboring communities. This school district cannot afford a school nurse, nor does it have a comprehensive health education program.

In addition to the problems of access to and funding for health care, the survey that we conducted showed that our adolescents, like others, have many health problems. **Substance abuse, early sexual activity and teen pregnancies, mental health,** as well as some **poor and unsafe health practices** are the problem areas that showed up most predominately.

There are some services available to meet these needs, but again they are limited and they are only reaching a minority of adolescents and their families at this time. Specifically lacking are inpatient or day treatment substance abuse programs for adolescents without funds. Mental health programs for those with no funds are also lacking.

In addition to limited or lacking resources, is the problem of lacking the knowledge of available resources. This is a problem for both adults and children. Children have an added disadvantage of not having access to resources, they usually do not know who to go to for assistance and have to rely on adults around them to identify their problems and obtain services for them. There is no systematic way to do this for all children and problems often go undetected until a crisis occurs. We need to develop better ways to prevent health problems and identify problems before they become crises.

We support the funding of health programs that target families and children who are unable to pay for services and lack insurance. Services need to be accessible, and tailored to meet the special needs of children. Please remember that **all** health needs must be addressed in order that our children grow up to be healthy, contributing members of our society.

We appreciate your interest in the health concerns of families and children and your belief that health care should be available to everyone. We share that interest and belief with you.

Sincerely,

Sara E. VanDeMark, Project Director
Lincoln Park Adolescent Health Advisory Committee
Lincoln Park High School
1701 Champaign
Lincoln Park, Michigan 48146

Medical Center

Southfield and Outer Drive
Allen Park MI 48101

Veterans
Administration

June 21, 1989

In Reply Refer To 553/00

Honorable Donald W. Riegle, Jr.
United States Senator
Wayne-Monroe Regional Office
1850 McNamara Federal Building
Detroit, MI 48226

Dear Senator Riegle:

Thank you for your invitation to attend the Senate Finance Sub-Committee on Health hearing at the St. John's Armenian Church in Southfield, Michigan on June 28, 1989.

Regrettably, at this time, however, I will be meeting with officials in Washington, D.C. on the Allen Park Replacement Project and will be unable to attend.

You can be assured of my continuing support of your untiring efforts concerning the problem of health care for the uninsured.

Best wishes for a successful hearing.

Sincerely yours,

James H Stephens

James H. Stephens
Director

"America is #1—Thanks to our Veterans"

VISUALLY IMPAIRED CENTER
725 Mason Street Flint, Michigan 48503 Phone (313) 235-2544

FLINT OFFICE
89 JUN 27 PM 12:38

June 26, 1989

Senator Donald Riegle
352 S. Saginaw Street
Flint, MI 48502

Dear Senator Riegle:

I am responding to your request for information on problems surrounding health care for the uninsured.

In the area of eye care, inadequate or no health insurance is a major problem, especially for the elderly. If an eye disease is not detected and treated in the early stages, partial or total blindness may be the result. The elderly who have no health insurance and inadequate funds tend to avoid going to an eye doctor. They then lose vision which often causes difficulties in functioning independently in their homes. This problem could be avoided if there were adequate health insurance for regular eye examinations and follow up treatments.

This is an area that needs to be addressed. Any assistance that the Senate Finance Subcommittee on Health could provide would be a step forward to helping those in need.

We appreciate your thoughtful consideration of this matter and are available to assist should you require any additional information.

Sincerely,

Judy De Jong CSW
Judy DeJong
Certified Social Worker

Memorials & Bequests
Accepted

June 27,1989

Honorable Donald W. Riegle, Jr.
United States Senator
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, Michigan 48226

Dear Mr. Riegle;

I am pleased to hear of your concern for those of us without medical insurance. We are one family of many without medical insurance.

My husband owns and operates a small gas/service station and I work part time. We have two children, one with chronic asthma. Hospitalization is strictly a "last resort" and prescriptions and doctor's office visits average $60.00 per month just to keep him out of the hospital. Private insurance companies exclude coverage for our son relating to respiratory problems due to his history. Blue Cross/Blue Shield coverage for our family is far too expensive, approximately $300 per month in premiums. For a family of four earning approximately $25,000 per year combined income and after taxes, there is not much left for such "luxuries" as health insurance coverage. I am hoping to find a full time position soon that offers health care coverage of some sort now that my children are older.

Those who have health care coverage do not fully realize how fortunate they are and often abuse their insurances because they do not have to pay for it out of their personal pocketbooks.

I pray everyday that nothing catastrophic happens to our family. We would be wiped out financially and more than likely forced on the welfare rolls after years of hard work. Is this the "Great American Way"?

In closing, I cannot even begin to offer a solution to this vast problem. However, I do pray for the wisdom for those of you who are knowledgable and who have a true concern for their constituents well being that a viable solution will be found.

Sincerely,

Mary Denise Vore

UNINSURED POPULATION ISSUES

BY

VERNICE DAVIS-ANTHONY, MPH
ASSISTANT COUNTY EXECUTIVE
OFFICE OF HEALTH & COMMUNITY SERVICES

WAYNE COUNTY, MICHIGAN

As of October 1, 1988 Wayne County assumed responsibility for administering the health care program which serves the Wayne County General Assistance population in accordance with provisions of PA 266, or HB 4452, passed in December of 1987. This program, called CountyCare, represents a coordinated effort between Wayne County, the State of Michigan, CountyCare providers, enrollees and others in implementing a managed health care program which provides a comprehensive range of health care services previously unavailable to this population.

Our General Assistance population consists, by program definition, of adults age 21 through 64. The age distribution of our covered population, numbering approximately 50,000 indicates that, of this group, approximately 38 percent are age 21 through 34; 29 percent are age 35 through 44; and 33 percent are age 45 through 64. The sex distribution is approximately 60 percent male and 40 percent female.

In accordance with HB 4452, the CountyCare program combines the General Assistance outpatient coverage -- previously administered by the State of Michigan -- with the Resident County Hospitalization, or RCH program coverage into a comprehensive managed health care system. Those persons determined eligible by DSS for the State's General Assistance (GA) Cash Grant program in Wayne County is the population enrolled in CountyCare. Wayne County has contracted with four (4) Plan Providers who have each, in turn, subcontracted with a variety of service providers to form the CountyCare delivery network, with over 170 actual delivery sites.

These Providers also make referrals for mental health services to appropriate entities within Wayne County. Effective October 1, 1989 Wayne County will also incorporate the Dental portion of GA Medical - currently under State Administration - into the CountyCare network. Once this is established, there will be over 180 locations where our enrollees can receive necessary and appropriate health care.

Each month a Wayne County resident is determined eligible by DSS for a GA cash grant, they receive a CountyCare identification card. This card identifies the Plan Provider the enrollee is assigned to and lists their Provider's 24-hour client information telephone number. As each GA client is enrolled, they receive information from their assigned Plan Provider as to which clinic and other service providers they should go to for care.

The County believes that this system of managed health care is a substantial improvement in terms of the ability of enrollees to access the health care system for preventive care. The County also believes that the managed health care system is much better able to positively impact the health status of enrollees when compared with the episodic, highly emergency room dependent utilization patterns experienced under the previous programs. A natural concomitant of this managed care approach is a more cost-effective health care delivery system. Providing enhanced access to primary care enables early diagnoses of problems that, left untreated until becoming emergencies, could result in the need for more costly inpatient hospitalizations.

A crucial component in any managed health care system is a well conceived and effective Quality Assurance program. Such a Quality Assurance program has been in place at both the Provider and County levels since program inception to ensure conformance to accepted standards of care. In fact, we have an entire Division devoted to monitoring the quality of care being delivered to our enrollees. Calls from patients and enrollees expressing a particular concern or request for information go directly to one of the three Registered Nurses who staff the PCMS Quality Assurance Division and, if necessary, to the CountyCare Medical Director. The situation is immediately assessed and the appropriate intervention is set into motion with follow-up contact made, as appropriate. Such monitoring of quality was, quite simply, absent under the previous programs.

Based on data collected from the first six months of CountyCare operation, inpatient admissions have been reduced by about 25 percent, with an associated reduction in average length-of-stay of 1.5 days. Outpatient visits were initially at a level consistent with the prior program but have recently been increasing and, due to our implementing a managed care approach, such visits are now part of an overall treatment plan.

We believe it is important to note that data collected to date suggests that CountyCare enrollees are getting appropriate, quality care and that any legitimate problems they may have that are brought to our attention are being addressed. Certainly, some new patients will also need some time to adjust and we feel that the process is already in place and works to address their concerns.

While Wayne County firmly believes that the CountyCare program represents a tremendous improvement in health care access and quality for General Assistance recipients, the County also recognizes that there continues to be a significant uninsured and underinsured population without health insurance of any kind, or with inadequate health coverage. This, of course, is not just a problem in Wayne County but statewide and nationwide.

Based on a report recently issued by the Michigan League for Human Services, there were over 992,000 persons lacking any health care coverage in Michigan in 1987 -- roughly 10% of the state's population. The largest uninsured group -- over 30 percent of the statewide total -- consisted of children up to 19 years of age. An additional 40 percent of the state's uninsured in 1987 consisted of individuals employed either full time or part time. Of this group, 61 percent were employed full time in 1987. Recent national estimates suggest that some 37 million Americans lack adequate health insurance and, of these, roughly two-thirds, or over 24 million, are employed persons and their dependents.

Wayne County's total population is approximately 2 million and, based on recent estimates, its uninsured population totals between 200,000 and 250,000 -- a figure consistent with the Michigan League for Human Services report estimating a 10 percent uninsured rate for the seven county Southeast Michigan area. Some estimates, in fact, cite a figure as high as 300,000.

As a member of the Governor's Task Force on Access to Health Care and as a local government representative, I bring to you several concerns. With the numbers of uninsured increasing not only in Wayne County, but in local municipalities throughout the state and the country, the local government, as the payor of last resort, cannot assume the additional load of providing health care coverage for these growing uninsured and working poor populations.

The number of uninsured persons in Wayne County who typically seek health care in a hospital setting -- often with a very high recidivism rate -- may result in a shifting of resources that could otherwise be used to care for CountyCare's, and other systems', patients in lower cost and often more appropriate settings.

The approach which we in Wayne County recommend, and which many health care providers are beginning to adopt, is development of a managed health care model -- such as CountyCare -- which treats each health care encounter as part of an overall treatment plan. Such a model also serves to institute controls over the cost of health care by providing economic incentives to providers, as well as to implement a quality assurance program to monitor the program's quality of care and the associated costs.

We also recommend that the definition of determining disability for Medicaid be revisited and expanded. The State Medicaid Program currently follows the Federal Department of Health and Human Services definition of disabled, which many feel has sufficient flexibility to allow such an expansion.

This issue takes on added importance in context of the AIDS crisis. Although CountyCare sees few AIDS patients so far, the existing impact has been felt by our providers, and the potential impact is very serious. Persons diagnosed with HIV cannot be made eligible for Medicaid until they meet the conditions of the existing disability definition, which can often take a year or more.

Clearly, a Federal policy and position is needed to address the needs of the uninsured and underinsured populations. Priority needs to be given to ensuring that all citizens have access to quality, affordable health care, yet such a policy must also deal pragmatically with the issues of cost control and appropriate access to care.

As Wayne County has demonstrated with CountyCare, a public/private partnership is a viable model to utilize, and any Federal policy which facilitates such a partnership should provide incentives and appropriate support for small businesses, where most of the working poor are employed, to participate.

Finally, it is imperative that incentives and appropriate support be provided to state governments to encourage participation in every state in the nation if we are to begin to adequately address the pressing needs of the uninsured and underinsured.

20157 Cheyenne
June 28 1989
Detroit Mich.

Honorable Senator Donald W. Riegle Jr.

Upon receiving your notification of the Hearing I was delighted to ~~no~~ no that someone was taking a tough stand on a sore on our Nation all of the Industrial Countries of the World have some sort of Health Ins.

It is way past the time for the U.S.A. to have a Comprehensive health plan I hope in the near future we shall have one I myself is a disable veteran who do Volunteer work in Allen Park, Mich I've worked in the Escort service, Medical Record and at the present time I'm working with the Chaplin, Chaplin Hunt who is an inspiration to be around I can afford health Ins do to the fact it's part of

3

My fringe benefits from Chrysler where I retires.

But there is thousand of people who don't have Health Ins. once I went to a Doctor I liked and I had Blue Cross and Medicare but he still wanted his money up front I dropped him like a hot potatoe!

So you see it's worse than most people know about I wish

4

In the near future Our Country can come up with a Health Ins Plan that will be a model for the World to shoot at, yours Respectively,

Gary W Wallen
Esq.

P.S. I belong to V.F.W
Post 1407 Ferndale Mich

WAYNE STATE UNIVERSITY
School of Medicine

Office of the Dean
1241 Gordon H. Scott Hall
of Basic Medical Sciences
540 East Canfield Avenue
Detroit, Michigan 48201

June 29, 1989

Senator Donald W. Riegle, Jr.
Chairman
Senate Finance Subcommittee on Health
for Families and the Uninsured
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

Dr. Robert J. Sokol, Dean of Wayne State University has asked me to respond to your request for written testimony for the hearing on "Healthcare for the Uninsured" held by the Senate's Finance Subcommittee on Health for Families and the Uninsured on June 28, 1989 in Southfield, Michigan. Unfortunately, it was not possible to provide our comments prior to the June 28, 1989 meeting, but I am forwarding them to you for possible inclusion in the collected testimony.

The Detroit Medical Center which is the Medical School's major hospital affiliate has also submitting testimony on problems represented by uncompensated care as faced by our hospitals. It is estimated that The Detroit Medical Center will provide uncompensated care in excess of $50 million to patients during the 1989 calendar year. That number does not include the lack of compensation for professional services provided by faculty physicians of the Wayne State University School of Medicine. Not only is there no compensation in caring for these patients, but our faculty face the added responsibility of supporting ambulatory services to such individuals as well as being at risk for malpractice claims in a State known nationally for its litigious atmosphere. The threat is that when faced with these problems, institutions which by their long history and tradition are committed to community service now face the hard reality of restricting services to the uninsured or face the alternative of bankruptcy. In like manner, faculty physicians will be hard pressed to continue to provide medical care without compensation.

The inadequacies of medicaid reimbursement in Michigan are becoming clearly evident and indeed expansion of services promised to medicaid recipients seems to anticipate the ability of the health care industry to underwrite such costs. In the days of competitive pricing for health care, there is no capability for costs shifting in order to provide expanded services to the medicaid population.

Some medical groups have been attracted to the recommendations of the National Leadership Commission on Healthcare which issued its report in February. In particular, Dr. Arnold Relman, editor of the New England Journal of Medicine has commented positively on the recommendations of that study. The Commission recognizes that neither the public sector nor the private sector alone is capable of resolving the problem. Rather it will require a joint effort using resources provided government, employers and beneficiaries in proportion to their means. Other somewhat similar proposals had been voiced by Alaine Enthoven in The New England Journal of Medicine. Regardless of the approach, the massive problem posed by the uninsured threatens to engulf hospitals and doctors alike.

It is increasingly clear that health care for the uninsured is everyone's problem, government, employers and the general public. Without some kind of coalition solution, other efforts will be piecemeal at best. We hope that Senator Reigle's Subcommittee might take a leadeship position along with others in Congress in developing a workable proposal.

Sincerely yours,

Robert E. Mack, M.D.
Assistant Dean
for Medical Center Relations

REM:hbr

FLINT OFFICE
89 JUN 22 AM 10:53

WHEELOCK MEMORIAL HOSPITAL
7280 State Road, Goodrich, Michigan 48438
(313) 636-2221

June 19, 1989

Senator Donald W. Riegle, Jr.
United States Senate
Sabuco Building
Suite 910
352 South Saginaw Street
Flint, Michigan 48502

Dear Senator Riegle:

Thank you for your invitation to attend the Senate Finance Subcommittee on Health hearing. Unfortunately, I will be unable to attend but would like to express my support of your efforts.

I am pleased to see recognition of the problems hospitals face in caring for uninsured or underinsured individuals. Much discussion has occurred in the past months and years about the problems of decreasing reimbursement through the Medicaid and the Medicare systems and not much attention has been paid to the increasing numbers of the uninsured or underinsured.

Access to health care will be a major issue as hospitals struggle to remain financially viable and to offer the myriad of services we presently offer. The hospital industry in general, I believe, has worked diligently to maintain services for all who present themselves to our institutions for care even though it has placed many of us in financial jeopardy.

Michigan, in particular, has seen a decline in the number of Medicaid recipients and that is one of the reasons given for the decline in Medicaid funding even though Medicaid funding still does not even meet the cost of services provided. However, the flip side to the decline in the Medicaid rolls is that many of these Medicaid recipients are now in minimum wage jobs, meaning they no longer qualify for Medicaid but they also are in positions that do not provide health care insurance.

My hospital, in particular, has seen an increase in the number of Medicaid cases we care for as well as an increase in the numbers of uninsured and underinsured individuals we care for. These two factors have resulted in higher write-offs on both the Medicaid and bad debts sides. The dangerous result of these issues is that we must use reserves to provide patient care. The reserves are intended to provide physical plant replacement, physical plant updating and acquisition of new technology. If these funds are used for patient care, it is obvious that the physical plant and technology may ultimately suffer.

Not only are we impacted by the Medicaid shortfall and the increasing proportion of uninsured and underinsured patients, but we're faced with inequities in the Medicare system as well. I know of no other business who is expected to operate like a business and yet must accept less than their cost to provide service.

It appears that access to care will be a major issue in the months and years to come as hospitals continue to lose money providing patient care services.

Thank you for an opportunity to present my views. If I can be of help in the future, please don't hesitate to let me know.

Sincerely,

Joseph W. Kyle

Joseph W. Kyle
Chief Executive Officer
Wheelock Memorial Hospital

JWK/dl

Whitmore Lake Health Clinic

FAMILY PRACTICE
PEDIATRICS
OBSTETRICS
GYNECOLOGY

June 13, 1989

Donald W. Riegle, Jr.
United States Senate
1850 McNamara Federal Bldg.
477 Michigan Avenue
Detroit, Michigan 48228

Dear Senator Riegle:

Thank you for allowing our small clinic to participate in a ever growing and serious problem, the Uninsured.

There are a great number of concerns:
1. Insurance for our seniors
    a. So many of our seniors today can not afford supplemental insurance coverage or the yearly medicare deductible requirement.
    b. Non coverage for medication for senior citizens under the medicare program. For example: seniors require larger amounts of prescriptions. More often these medications are for long term or life time treatment

Suggestion:
1. Cover seniors with a special program to cover at least a percentage of their medications, hearing aids, eye glasses and other essential supplies.
2. Establish a Medicaid program that is not difficult for the seniors to complete and receive, or even automatic coverage.

Pre-Post Natal Care:
1. Many women are working but do not receive health insurance, or receive Obstetric insurance coverage, therefore do not seek pre-natal care or post-natal follow up.

Suggestion:
1. All women requiring pre-post natal care should have medical coverage for that period of time.

Children:
1. Many children are covered under the Medicaid Program for a short period of time after birth. When the parent should return to work and no longer qualify, the child is removed from the program with no insurance coverage.

Suggestion:
1. No child in the United States should be without health care coverage.

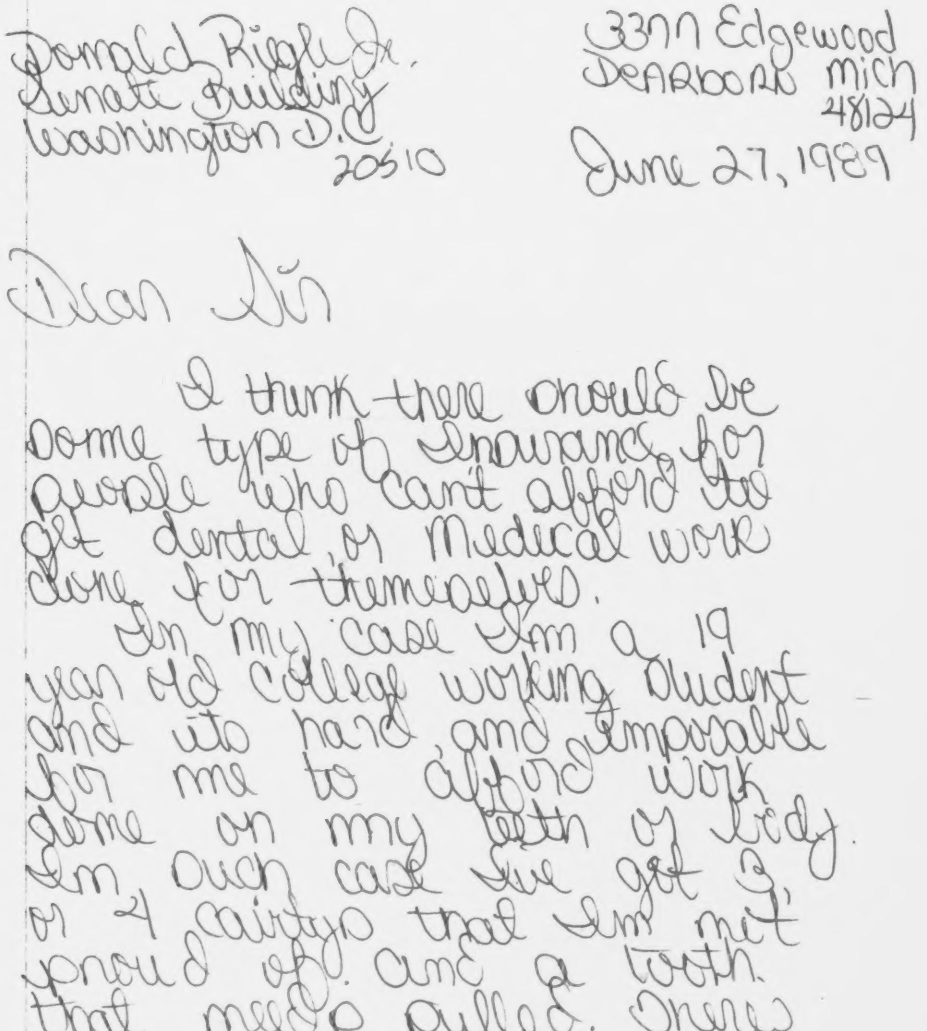
If priority must be chosen for health care coverage, no senior, pregnant women regardless of age or child should be without a health care program.

I look forward to participating on June 28th.

Sincerely,

Hilda M. Weiser

Hilda M. Weiser
Executive Director



Donald Riegle Jr.
Senate Building
Washington D.C.
20510

3377 Edgewood
Dearborn Mich
48124

June 27, 1989

Dear Sir

I think there should be some type of insurance for people who can't afford to get dental or medical work done for themselves.

In my case I'm a 19 year old college working student and its hard and impossible for me to afford work done on my teeth or body. In such case I've got 3 or 4 cavitys that I'm not proud of. and a tooth that needs pulled. There's nothing I can do now because can't afford the prices of medical treatment but if I wait any longer I maybe to late. I wish there were some sort of plan for people with low incomes.

I Know this letter may not say much, and I Know it may not do much. But I hope that there's something that can be done for low Income people. I dont want to go on aid, and paying for Insurance is to high! You cant really save because you pay car Insurance, every month something breaks down, you pay rent. times are just hard right now and some people like myself dont have a fighting chance! I hope there's something that can be done

Sincerely:

Jenny [illegible]

June 26, 1989

Senator Donald Riegle
C/O Wayne Monroe Regional Office
1850 McNamara Federal Building
477 Michigan Avenue
Detroit, Michigan 48226

Dear Senator Riegle:

I was pleased to receive your invitation to the hearing at St. John's Armenian Cultural Center on June 28, 1989; regarding access to health care for uninsured individuals.

My concern is indirectly related to the issue at hand, i.e., availability of some drugs to treat catastrophic illnesses like cancer. Some of these drugs are not covered by certain medical insurance plans, even though they have shown a great deal of promise in the treatment of these diseases.

For example, my husband has non-Hodgkins, mantle zone lymphoma, a form of cancer which responds very well to a drug called Interferon. However, for some reason, our insurance does not cover the cost of this drug. To provide this drug for ourselves would cost us a minimum of $100 per week. As you can see, a person could go broke trying to stay alive. Such an expense would rapidly deplete our family's savings; and, as a result, has forced us to resort to another, less effective treatment alternative.

It is our hope that, in the future, drugs like this will be available to anyone who needs them. It is sad that, given the state of our technology, people have to die because they can't afford the treatments.

If you wish to confirm any of this information, please contact my husband's oncologist, Dr. David Leichtman; telephone (313) 569-2760; Providence Medical Building; Southfield, Michigan.

Thank you for taking the time to hear my opinion.

Sincerely,

Margaret Wisniewski

Margaret Wisniewski
42266 Waterfall
Northville, Michigan 48167
Telephone: (313) 344-8910

mmw

Workforce Inc.
TEMPORARY HELP AND MORE

June 21, 1989

Senator Donald Riegle
Senate Subcommittee on Health
for Families and the Uninsured
477 Michigan Ave.
Detroit, MI 48226

Dear Senator Riegle:

I am responding to your letter to NFIB members regarding the Senate Finance Subcommittee on Health hearing you are holding on Wednesday, June 28, 1989 at 10:00 a.m.

I, like many businessowners, cannot afford to take time from my work in the middle of the week to testify in person. However, I would like to submit the following information relevant to your concerns regarding access and availability of affordable health care for all Americans.

I believe that health care is available and affordable, and I cite the following figures in support of that belief:

Premium for standard medical insurance with $250 deductible, 80% paid up to $2,500, 100% over that:

Age	Premium/Group Policy	Premium/Individual Policy
22	$76.73/month	$58.25/month
32	113.04	68.58

This is a sample of **actual** cost as of 2-1-89 for individual coverage.

As you can see, coverage for the average American is affordable. Trying to foist this problem on small businessowners will not solve it.

The only real problem with obtaining coverage, or affordable coverage is those who have pre-existing conditions. Many small businessowners have fewer than ten employees, and that is the cutoff for "insurability" regarding pre-existing conditions. So again, trying to solve the problem by making the businessowner responsible does not solve it.

Your concern is understandable and very much appreciated, but this is not something that will improve with government intervention or by "giving" health care to citizens by whatever means. I have surveyed some of my employees, and they are simply unwilling to pay the premium out of their own pockets because it is an intangible that has no value to them until they have to use it. That certainly does not mean that it is not affordable or available.

I appreciate your taking this information and point of view in to consideration, and sincerely hope you will turn away from any idea of mandating health care for all citizens on the backs of small business.

Sincerely,

Pamela Boyd
President

PBdl
cc: NFIB-Michigan

June 28, 1989

A Free Market Position on the Health Care Crisis

In order to effectively deal with the health care crisis, it is necessary to correctly analyze the problem. The problem is that the current economic climate is inadequate in providing sufficient prosperity for citizens to obtain needed health care.

Even within the current disabled economy, the dimensions of the problem could be significantly reduced by government undertaking to organize those individuals whose means are not sufficient to provide for themselves the high-priced individual policies for which they are eligible, but whose means are sufficient to afford the rates obtainable as participants in a cooperative group. This non-coercive role is the only appropriate one for government, and would provide a zero cost solution that would benefit great numbers of persons.

Those unable even to afford group rate health coverage are clearly the most serious victims of an economy crippled and burdened by regulation, inflation, privilege, and other costs of government intreference. The only lasting solution for them is the release of the prosperity that the free market will supply in the form of lower costs and higher wages with full employment.

The only problem remaining would be those unfortunates whose handicaps prevent them from working, and thus providing for themselves. Such persons are the appropriate recipients of charity, for which there would be no lack of funds or good will in the prosperous climate that would prevail.

Any other solution to this problem only further drains the productive econmoy and hampers its ability to provide services for anyone, leading to rationing and shortages as are to be found everywhere that socialized medicine is practiced.

Doreen M. Wright

Pete Hendrickson / Doreen M. Wright
Co-Chair, Libertarian Party of Oakland County

YOUNG PEOPLES DENTISTRY OF DETROIT, P.C.
Deryl E. Williams, D.D.S., M.S., President
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PHONE: (313) 342-7900

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6-24-89

Dear Senator Riegle:

Dr. Norman Clement, and myself, will be glad to share with you our research on the Medicaid Dental Health Care system on June 28, 1989.

Our mutual concerns will become a synergistic experience.

Sincerely,

D.E. Williams

Re 6-24-89

DONALD W. RIEGLE, JR
MICHIGAN

COMMITTEES
BANKING, HOUSING, AND URBAN AFFAIRS, Chairman
FINANCE
BUDGET

United States Senate
WASHINGTON, DC 20510

June 8, 1989

Dear Friend:

I am pleased to notify you of a hearing by the Senate Finance Subcommittee on Health that I will hold on Wednesday, June 28, 1989, at the St. Johns Armenian Church Cultural Hall at 22001 Northwestern Highway in Southfield, Michigan. The hearing will focus on the problem of access to health care for uninsured individuals, and will begin at 10:00am. Due to limited time we have invited witnesses to present their testimony orally. All interested individuals are welcome to submit their testimony in writing to a member of my staff to be included in the official transcript of the hearing.

As Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, I am working to address the many problems confronting individuals needing health care and health care providers in Michigan -- and across the country as well. I believe high quality, affordable health care should be available to all Americans and their families. I have been working to ensure adequate funding for federal health programs, including Medicare and Medicaid, and **to improve our overall health care system**. One of my priorities is to see that all Americans have access to health care when they need it, and I would certainly value any comments you may have on the complex issue of health care for the uninsured.

I hope that you will be able to join me at this important hearing and I look forward to any written testimony you would like to provide on the problems surrounding health care for the uninsured and suggested solutions to this tragic problem.

I look forward to seeing you on the 28th.

Sincerely,

Don Riegle

Donald W. Riegle, Jr.

DWR/el

MICHIGAN REGIONAL OFFICES

WAYNE MONROE
1850 McNamara Federal Bldg
477 Michigan Ave
Detroit MI 48226

SOUTHEASTERN
Century Center Bldg 3d Floor
30800 Van Dyke
Warren MI 48093

EASTERN
Sobucn Bldg Suite 910
352 S Saginaw Street
Flint MI 48502

CENTRAL
700 Washington Square Bldg
109 W Michigan Ave
Lansing MI 48933

WESTERN
Suite 716 Federal Bldg
110 Michigan Ave NW
Grand Rapids MI 49503

NORTHERN LOWER
300 Front Street
Traverse City MI 49686

UPPER PENINSULA
Room 323 P.O. Bldg
200 W Washington
Marquette MI 49855

The Journal of PEDODONTICS

Volume 13, Number 1 Fall 1988

Why poor Johnny doesn't smile: A preliminary report from Dental Survey of America on state medicaid programs

NORMAN J. CLEMENT

In August of 1987, the Congress of the United States passed and the President signed into law 42 U.S.C. 1320a-7a as amended by Public Law 100-93, which in short states, "if a health care provider is found in violation in Medicare and state health care programs then he/she is mandatorily excluded from every Medicare and state health care program throughout the country and territories and subject to disciplinary action from each individual state in which the provider may be licensed." The Congress along with the President assumed each Medicaid, state-run program was the same and this piece of legislation was long overdue and made sense.

In mid-January, a group of concerned citizens lead by Norman J. Clement, a private dental practitioner, formed *Dental Survey of America* and immediately began reviewing the content of dental provider manuals from Medicaid dental programs of 50 states and 5 territories. This group is releasing some of the preliminary findings, which are both shocking and disturbing concerning the *State of America's Dental Health Care for Poor Americans.*

If there is one universal opinion concerning the *Medicaid Program*, it is shared by this author and expressed by Karen Erdman and Sydney Wolfe, MD of *Public Citizens Health Research Group*, co-authors of *Poor Health Care for Poor Americans* (a study of state Medicaid programs) is that "Medicaid is a program that makes *no sense.*"

Although dentistry has gone through a tremendous technological change in the past 40 years with the advent of light-cured composites over silicate cements or air turbine, high-speed instruments over foot-pedal belt-driven hand drills, safer anesthetics to comfort long dental procedures, the dental policies and procedures in most state-run dental Medicaid programs remain abysmal, primitive, or nonexistent.

Clearly Medicaid is a program that operates outside the practice of dentistry and, in fact, in all, but a few states, local dental societies and even State Boards of Dentistry have very little say in the dental policies written by state-run Medicaid dental programs. We found every Medicaid program required that an individual be licensed by the State Board of Dentistry in the specific state in order to provide services for a Medicaid recipient.

One of the most detrimental restorative materials ever used in dentistry was known as the silicate cement. At one time silicate materials were used on anterior teeth because when initially placed, it had a shade appearance similar to the natural tooth. Silicates were also known to discolor and shrink very readily, resulting in poor marginal adaptation. Silicates were also known to be highly toxic to the underlining dental pulp, which often destroyed the tooth and many times led to extraction or root-canal therapy. Yet even though silicate restorations haven't been seen in dentistry for over 30 years, they can be found in the California, Florida, Massachusetts, and Michigan Medicaid dental provider's manuals. In fact, in both the Florida and Massachusetts Medicaid dental provider manuals, their use is advocated for children's front teeth.

> Silicate restorations are for primary or permanent anterior teeth and the buccal surfaces of the first bicuspids" Fla. p. 4-3 HRSM 230-22. 11/81.
>
> Silicate restorations are reimbursable only for primary or permanent anterior teeth and the buccal surfaces of the first bicuspids. Mass. p. 4-14 Den-1 11/29/79.

To the modern dental practitioner the use of a silicate cement restoration would be equivalent to one prescribing thalidomide as the drug of choice for pregnancy.

In Hawaii, the Medicaid provider manual has over 500 pages of everything, but dentistry and seven pages labeled "Benefit Limitations" for dentistry. Indeed, it was the conclusion of this author that it is far easier for one in Hawaii to have surgery paid for by Medicaid to become a transsexual than it is for a child to have a tooth filled.

Over two years ago, the American Dental Association's Council of Dental Care Programs at the request of one dentist reviewed the Medicaid Dental Provider's Manuals for Adults and Children's Dental Services in the state of Florida and found:

> Some procedure definitions inconsistent with the nomenclature in the Association's code on *Dental Procedure and Nomenclatures* and other procedure definitions to be incomplete or otherwise incorrect based on current accepted dental practice.

The Council Staff member also felt that "both manuals needed to be revised and updated." Yet, the State of Florida Department of HRS and the Florida Dental Association have failed to change any of the technical aspects of these two provider manuals other than a recent fee increase, which was the first in some twenty years.

It was even more disturbing to find that the same policies and procedures definitions found in the Florida provider manuals were nearly identical to what can be found in Massachusetts and Maine dental provider manuals. In fact, all *three* dental provider manuals describe a simple extraction as:

> The removal of a permanent or deciduous tooth (baby tooth) by the closed method or FORCEP ONLY technique in which a flap is not retracted.

and a surgical removal of an erupted tooth is the:

> Removal of an erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of aveolar bone in order to extract or section of a tooth.

This author has interviewed over 200 dentists including dental educators, dental researchers, private dental practitioners, both the past and present president of the National Dental Association along with two of America's foremost oral maxillofacial surgeons, Raymond J. Fonseca, DMD and James R. Hayward, DDS, MS. and to this date *no one* has ever heard of the open or closed method of extraction technique being referenced [this author did come across forcep only technique being referenced to the 16th century to the patron saint of dentistry.]

R.J. Fonseca DMD, Chairman Department of Oral Maxillofacial Surgery University of Michigan States:

> It is my opinion that the section on oral and maxillofacial surgery is not compatible with the practice of oral and maxillofacial surgery specifically the reference

of differentiating between open and closed extraction is too simplistic and does not reflect real clinical practice.

It was also shocking to find that some of America's worst Medicaid programs for dentistry are in states where America's foremost schools of dentistry can be found. Michigan, Massachusetts, and North Carolina are states where leading dental schools are located and where Medicaid dental programs fail to meet the minimum standards of dental care as set forth by the American Dental Association. In the state of Florida, for example, a Medicaid recipient over 21 receiving a single radiograph of a single painful tooth must by law have *all* of his/her teeth removed for the construction of a denture in order for Medicaid to cover the services of that single dental radiograph.

Fear and Finance is what keeps the majority of Americans out of the dental office. *Pain* is what brings them in. This is especially true for poor Americans. The total removal of one's entire dentition for the elimination of pain from a single tooth is the dreadful choice a poor person on Medicaid 21 or older has to make everyday in the state of Florida. For the dental provider's failure to follow unsound Medicaid policy is a felony and can lead to one being charged with a *criminal* indictment by the *State's Office of the Auditor General's Medicaid Fraud Control Unit*, which has resulted in some dentists being found guilty and at least one dentist serving *prison* time.

What is equally disturbing is that these Medicaid policies in individual states varies so widely that what is the standard practice of dentistry in one state could be *felony fraud* in another.

The review by this author suggests that it is incumbent that individual state professional licensing and regulation agencies through their Boards of Dentistry get control of these Medicaid dental programs.

1. Boards should require that Medicaid dental policies and procedures be written by dentists knowledgeable in various specialties of dentistry and not by lawpersons or part-time dental consultants.
2. Boards need to take drastic action such as unilateral implementation of *Emergency Orders* prohibiting all licensed practitioners from participating or seeing Medicaid clients until this program has been thoroughly overhauled and updated to meet the

minimum practice of dentistry in these individual *states*.

3. That if necessary some state programs which fail to clean up their act in 90 days be taken over by the Federal courts and appointed a trustee for a period of two years in order to comply with the current standard practice of dentistry.

James R. Hayward, former department chairman of Oral Surgery, University of Michigan and former president of the American Association of Oral and Maxillofacial Surgery states, "Arbitrary decisions, often not in the patient's interest are made by public health dental consultants and their individual opinions are not easily challenged." He goes on to say, "It is obvious that a self-respecting dental practice cannot be conducted at the *dictates of Medicaid*."

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The toothgate scandal: How the medicaid dental program in America is a national disgrace

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Introduction

If the report "Why Poor Johnny Doesn't Smile" was describing a dental chair which collapsed when the dentist was treating a patient due to metal fatigue of a certain bolt or a dog food which was tainted and caused some pets to go into convulsions, the Federal Government and consumers groups throughout the country would swiftly act to remove these defective products from the market place. If the report "Why Poor Johnny Doesn't Smile" was about a foreign government which required its poor people to have all their teeth removed and entitled them to only one denture per lifetime, the Department of State, United Nations, and other concerned world government leaders would condemn that foreign government for Human Rights violations. Medicaid, the health insurance for poor Americans which is State run and Federally funded is both a defective product and a violation of the human rights of all poor Americans.[1]

The Health Care Program for Poor Americans federally funded and state operated has sent some dentist to jail for literally practicing dentistry. Medicaid has destroyed the lives and ambitions of some of America's finest trained dentists who have reached to help the less fortunate through strong arm legal tactics which have also run many others who were willing to help poor Americans off the medicaid program. **What most citizens in our country are not aware of is that throughout America the medicaid dental program is being illegally operated outside the practice of dentistry and most states run medicaid programs are in violation of federal mandates, federal law and federal court orders.**[2]

It is inevitable that some children and adolescents will lose permanent teeth to dental disease or trauma. The removable partial has long been established in dentistry as the single most useful appliance for the management of space and the restoration of masticatory function as the result of early loss of permanent teeth in adolescent children its presence is necessary for the prevention of hypereruption of opposing teeth into the missing space and the collapsing of the entire dental arch (shifting teeth resulting in spaces between the teeth). Under the medicaid program in Michigan and in Florida the policies are written in such a manner that very few children, if any, would qualify for a removable partial denture. In Michigan the policy reads: removable partials are only done where there are (All RECIPIENTS) "fewer than six teeth are in occlusion in posterior areas." In Florida it states: "removable partials are only done where there are less than eight posterior teeth in occlusion."

To the lay person, who may understand very little about dentistry, this policy would have merit, but to a dentist it would be clear that one would have to butcher a child in the dental chair in order to qualify him/her for a removable appliance. We know as dentists that there are 32 permanent teeth present in the normal adult dentition. We also know that there are 12 anterior teeth and 20 posterior teeth including third molars. Using simple arithmetic it should be clear that this policy, if carried out, would be devastating to a young adolescent's mouth.

For example, a child of 14 years of age should have 16 posterior teeth opposing each other, if an adolescent loses her first permanent molar to dental decay, the dentist in Michigan must now remove 10 more back teeth in order to get paid for doing a removable partial denture in this young lady. Even more ludicrous is the fact that if (one or more posterior teeth do not oppose each other, the same child would fail to qualify for a removable partial denture at all. Fortunately the dentist in Florida would be required to remove 8 posterior teeth but would be faced with the same dilemma if one or more posterior teeth did not oppose each other.[1]

The Federal District Court of Appeals for the fifth Circuit ruled in ***Mitchell v Johnston*** cited as **701 F.2d 337(1983)** pg 349, that "the elimination of partial dental appliances on posterior teeth was not based on medical necessity but, rather, on the type of condition to be treated, and was wholly unrelated to the accomplishment of the purpose of EPSDT legislation." As quoted from the court's decision "this finding is also well supported by the record. Expert testimony established a fairly extensive need for the eliminated appliance. Id. at 191-92. Elimination of the appliance could result in periodontal disease, and shifting, misalignment, and possible destruction of front teeth. Indeed, this cutback, coupled with the elimination of posterior root canals, removed all of the basic approaches available to a dentist to deal with diseased or missing posterior teeth. TDHR's refusal to cover root canals for posterior teeth meant that seriously damaged teeth would have to be removed. ***Once removed, however, the posterior teeth could not be replaced with dentures unless the dentist removed more of the child's teeth—including healthy teeth.*** This is the type evidence that led the district and the experts to the conclusion that the remaining list of allowable procedures was inadequate to meet the needs served by a restorative dental program. Id. at 192-93.[1]

This statement alone from the court makes the entire section on partial denture appliance in the States of Michigan and Florida Medicaid Dental Programs in noncompliance on point. Further in the same court decision the district court ruled and the Appeals Court affirmed that, "when state voluntarily and knowingly accepts terms of federal-state 'contract' state is required to fulfill its mandatory obligation under that federal-state contract."[3] The fact that the States of Michigan and Florida have to follow their mandatory obligations in failing to change its policies and procedures for the removal prosthetic appliance makes these programs illegal and a clear and present danger to children's health care. Moreover on July 15, 1988 Kay Johnson of the Childrens Defense Fund Washington, D.C. wrote, "with regards to dental services, each state EPSDT program is required by federal law to provide all dental care, at as early an age as necessary, which is needed for the relief of pain and infections, restoration of teeth, and maintenance of dental health (42 CDF Section 441.56(c) (2) 1985). The

Health Care Financing Administration has broadly interpreted these requirements (Guide to Dental Care, EPSDT-Medicaid. Pub. No. HCFA 24515), and a federal court affirmed the broad intent of this language (*Mitchell v Johnston* 701 F 2d 337, 5th Cir, 1983).[5]

Why Poor Johnny Doesn't Smile
Part II

The celebrated case *Mitchell v Johnston* (Cite as 701 F.2d337(1983) affirmed the intent of Congress and the Federal Government to provide quality dentistry to poor children under 21. The findings by the 5th Circuit Federal District Court of Texas affirmed by the Federal Appeals Court was so broad and so sweeping it made possible comprehensive dental services including orthodontics available to poor Americans and made impossible for any State to avoid, frustrate or cut in any form or fashion federally mandated orders as intended by the will of the Congress of the United States of America to such services available under EPSDT.

Almost five years after the Federal Courts ruled in *Mitchell v Johnston* the State of Florida's Medicaid Dental Program officials have failed in every form and fashion to bring its program into compliance with the Federal Court ruling and federally mandated services. One clear example of The State of Florida's contempt for EPSDT guidelines was the mandated requirement of Orthodontic care (PHS 1980). On May 9, 1985, E. Ronald Niswander for George R. Holland Regional Administrator Health Care Financing Administration issued Transmittal Notice Region IV, Program Identifier: MCD-18-85(PO)
TO: All State Medicaid Directors and EPSDT Coordinators

Subject: Mandatory Coverage of Orthodontia Through the Early and Periodic Screening, Diagnosis and Treatment Program

It has come to our attention that several States in this Region still fail to provide medically necessary orthodontics through the early and periodic, screening, diagnosis and Treatment (EPSDT) program as required. This is to remind States of the regulation at 42 CFR 441.56(c)(2) unless this service is made available to children (through EPSDT) by July 1, 1985.

The EPSDT regulation (effective January 29, 1985) at 42CFR 441.56(c)(2) require, just as the previous regulation did (42 CFR 441.56(b)(2), the States provide for "Dental care . . . needed for relief of pain and infections, restoration of teeth and maintenance of dental health." Although HCFA has not defined "dental care" in EPSDT either in the regulation or the other publication, HCFA's position has been that the correct interpretation of the EPSDT and other regulations is that medically necessary orthodontic services could not legally be denied to an EPSDT participant.

If you have any questions about this issue, please contact Cathy Kasriel that (404) 221-2407.

On July 1, 1988 the State of Florida implemented its Orthodontic program nearly three years to the date that Mr. Niswander issued Program Id MCD-18-85(PO) and 8 years from when orthodontic care was made a part of the Medicaid program for all States. Ironically in testimony against one dentist Medicaid program Director Marie Funderburk stated that orthodontics was not a covered service under Florida Medicaid program. The dentist was terminated from Medicaid for violating Federal and State laws governing Medicaid based on Ms. Funderburk's testimony. To this date the State of Michigan was failed to provide medically necessary orthodontics to any Medicaid recipient qualified in Michigan.

Dental Survey of American obtained on July 12, 1988 from Daryl E. Williams DDS., MS., of Detroit, Michigan a Regional Letter from the Department of Health and Human Services dated Nov. 10, 1981.

Subject: Medicaid Policy on Medically Necessary Orthodontics Services Under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Background

The purpose of this Regional Letter is to clarify Medicaid policy on medically necessary orthodontic services under the EPSDT program.

The provision of orthodontic services under Medicaid, and specifically EPSDT, has historically been at the State's option. However, in two court decisions (*Brooks v Smith*, Supreme Judicial Court of Maine, April 30, 1976 and *Philadelphia Welfare Rights Organization v. Shapp*, U.S. Court of Appeals for the Third Circuit, July 9, 1979), it was held that the State must provide medically necessary orthodontic services as part of its program for early and periodic screening, diagnosis, and treatment in order to comply with Federal Requirements.

In view of the court decision and the regulation governing the EPSDT program, *HCFA issued a Medicaid Action Transmittal No. 80-78, dated October 1980, interpreting the regulation as requiring States to provide for medically necessary orthodontic services under the EPSDT program.*

Policy

Based upon the court decisions and *AT-80-78* comments, HCFA emphasizes that orthodontic policy under EPSDT requires States and territories to provide for medically necessary orthodontic services as a part of the dental component of EPSDT in severe cases where the condition is correctable by orthodontic procedure.

The above memo clearly establishes that medicaid officials in Michigan and Florida are *negligent by maintaining the Dental Program out of Compliance in violation of Federal regulations for almost 8 years* thus denying access of medicaid recipients to proper and legally required orthodontic care.

What Is Technically Wrong With Medicaid Dental Policies

Nowhere does The State of Florida HRSM 230-22 Dental Provider manual for Childrens Dental Services is more flagrantly in error, illogical to the policies of dentistry, EPSDT and the will of the Congress to provide health care than in the area of extraction of asymptomatic impacted teeth. The statements below once again clearly demonstrate how Florida medicaid policies are a *clear and present danger* to the medicaid recipient. These policies are technically incorrect and the dental provider would be providing substandard dental care, but the difficulty here below is that the public, lacking understanding of dental procedures, would probably not know the difference. To the dentist these policies would be equivalent to a physician performing heart bypass surgery using a butter knife.

From HRSM 230-22 October 15, 1981 Page 4-7, 4-12 *Oral Surgery.*

> (3) The surgical removal of asymptomatic third molars is not compensable. Surgical removal of third molars as a preventive or prophylactic measure is likewise not compensable. Since full bony impactions are rarely symptomatic, more attention is given to soft-tissue or partial bony impaction. The removal of third molars for suspected tempero-mandibual joint referred pain is not compensable. All prior authorization requests for the surgical removal of third molars must include a written statement from the dentist stating that symptom of swelling, prevalent infection, or consistent pain is present.

> State of Michigan, Rev. 5-20-82, Chapter III pg 32. Medicaid Dental Manual "The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt pathology is not covered."

Raymond J. Fonseca DMD, Chairman of the Department of Oral and Maxillofacial Surgery University of Michigan states that the contention that bony impaction are rarely symptomatic is erroneous.

The Appeals Court Concluded in *Mitchell v Johnston* that: 8. Nonsymptomatic Extraction of impacted Teeth:

> The district court also concluded that nonsymptomatic extraction of impacted teeth was a necessary EPSDT service and we agree. The testimony at trial clearly indicated that dental conditions do not always manifest themselves in the form of overt symptoms. Thus, the district court correctly held that the purposes of the program were frustrated since the treating dentist was required to wait until the condition culminated in overt, painful, costly symptoms before extraction was an allowable procedure. Record, vol 4 at 775. Quite clearly, several severe dental problems could develop without overt symptoms. Record, vol 10 at 199-200 necessary service was improper."

The American Association Oral and Maxillofacial Surgeons (AAOM) has stated in their Newsletter that, "timely removal of impacted and unerupted teeth (e.g., third molars), preferably between the ages of 15 to 25, is a valid and scientifically sound treatment rationale. The overwhelming body of clinical evidence shows that patients with impacted teeth who wait until symptoms appear before having them removed suffer risks of undue discomfort, prolonged recovery periods, increased cost of treatment and danger to their general health. The popular concept that if impacted and unerupted teeth don't bother you, don't bother them, is not supported by the weight of clinical evidence compiled over many years. The AAOM recommends that the public should consult an Oral and Maxillofacial surgeon or dentist before any problems develop. This is preventive dentistry. Waiting for impacted and unerupted teeth to cause pain or more serious problems will only result in unnessary complications and additional cost for treatment.

Anyone who was in possession of a pencil and a piece of paper could have written the American Association of Oral and Maxillofacial Surgeons at 211 E. Chicago Ave., Chicago, IL 60611 or called at 312-642-6446 and gotten the newsletter on Impacted and Unerupted Teeth for free.

Conclusion

The sad but true fact is that today 96% of the Medicaid Dental Manuals and programs still remain substandard and for this reason many dentists have abandoned the Medicaid program across the country. States, such as Michigan, Massachusetts, North Carolina where America's foremost Dental Schools could be found have some of America's worst Medicaid Dental Programs. In the State of Florida, Michigan, and South Carolina for example a Medicaid recipient over 21 is only eligible for extractions leading up to a denture there are no provisions for emergency dental care services. Fear and finance are what keep the majority of Americans out of the dental office; pain is what brings them in. The extraction of one's entire teeth is a dreadful choice poor Americans in many of our states over 21 have to face everyday from pain of a single tooth.[6]

There is no question that in America the Medicaid program for Dentistry and Medicine is a *National Disgrace*. In 1969, under the chairmanship of Harvey Webb, Jr., the legislative committee of the National Dental Association presented a statement of its Board of Trustees criticizing the dental establishment for neglecting the poor and the federal government for its handling of dental-care programs.[7]

> From past experience we cannot assume that the dental profession as we know it and as represented by American Dental Association acts in the best interest of the poor consumer. . . . We submit that on this basis of past performance, the Department of Health, Education and Welfare in general, the Division of Dental Health and bodies appointed to supervise the equitable administration of Federal dental-care programs, have left much to be desired and that the NDA can no longer afford to stand by and observe injustices perpetrated against the poor.[7]

On August 15, 1988 at the 75th annual convention the Board of Trustees/House of Delegates of the National Dental Association held in Detroit, Michigan, accepted in principal the findings of Dental Survey of America led by Norman J. Clement, Daryl E. Williams and Dalton Sanders that "clearly medicaid is a program that operates outside the practice of dentistry and many procedures, policies are primitive, abysmal or nonexistent in the practice of modern dentistry." Upon recommendation of the reference committee the Board of the National Dental Association agreed that a major study be undertaken by the organization to address the crisis of Dental Health Care for Poor Americans in this Country.

The California Dental Association is suing the Medical program for the State of California for failing to provide adequate dental services to poor in that state. In Massachusetts, Karen Edlund, Acting Director Project Good Health, Health choices unit of the your Department of Public Welfare for the State of Massachusetts wrote on July 6, 1988, "the Massachusetts Medicaid Division has long been aware of the problems with its dental program including the manual." There is no question that the Medicaid Dental Program as it is the America is a National Disgrace.

Dental care is health care, for most poor Americans and especially those in who are black, this aspect of health care remains a long way off.

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Review of the state of Florida's dental medicaid program

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Introduction

Dental Survey of America, conducted a comparative review of state run federally funded medicaid dental programs manuals throughout the country. It appears nearly all state run federally funded medicaid dental programs fail to meet the **minimal** standards for dental care in this country as recommended by national established dental organizations. We found that nearly all state run federally funded medicaid dental programs were in *non compliance* with their own state regulations governing the practice of dentistry and also were in *violation* of federal guidelines as set forth by congress for the administering of medicaid dental programs. Almost 96 percent of state run federally funded medicaid dental programs manuals which we reviewed had dental policies and procedures that were either inconsistent, or incorrect, and some had dental procedure that were *non existent* in the current practice of modern dentistry.

We found state run federally funded medicaid dental polices and procedures varied so widely from state to state that standard practice of dentistry as set forth by established dentistry was *felony fraud* in several states.[1]

Dental Survey of America has complied and reviewed several State Medicaid Dental Provider Manuals to assess their current appropriateness in providing guidance to the conduct of these State programs and in assuring quality dental care for eligible beneficiaries. Our findings clearly established what appears to indicate that many states have undermined the integrity and intent of Congress under EPSDT (Early Periodic Screening, Diagnosis and Treatment) Legislation to provide all comprehensive dental care and medically necessary orthodontics by hindering health care providers through harassments, indictments, and prosecutions.

The Florida Dental Medicaid Program is likely an illegally operated program and has been that way since its inception. There is no doubt that other state run medicaid programs are in the same category as seen in Florida but Dental Survey of America with information provided by the Children's Defense Fund in Washington, D.C. has uncovered the most flagrant abuse and violations of national medicaid policy and procedure on a part of medicaid officials in administering this state run federally funded program.

Composite Restorations: An Imminent Danger

It is very difficult for most people outside the field of Dentistry to understand how these procedure definitions are confusing to a dentist and are an **imminent danger** to the dental patient. One section in particular Dental Survey of American has highlighted was the procedure definitions for composite restorations as found in the Florida, Massachusetts and Maine Medicaid Dental Provider Manuals. The comparative study done from these 3 manuals demonstrates how some states have designed obvious technical failure in their policy and procedures which do not adhere to the standard practice of dentistry. It can also be clearly demonstrated how these definitions have been designed to cheat dental providers when billing for services. We theorize at one point several states dental societies as is apparent from the Wisconsin Medicaid Dental Provider Manual recognized there were serious problems and attempted to have the definitions for policy and procedures either clarified or corrected.

The definitions found in the following manuals on composite restoration demonstrate how the simple procedure for class 3 composite restorations can land a dentist in jail because the Provider Manual is inaccurate.

Commonwealth of Massachusetts Medical Assistance Program Provider Manual Series Dental Manual page 4-14 date 11/29/79 cite 106 CMR 420.

(C) *Composite Resin Restorations and Pins (Service Codes 060226, 060229, and 060231).*

(1) Composite resin restorations are reimbursable only for permanent anterior teeth and the buccal surfaces of the first bicuspids.
(2) Payment for two composite resin restorations is the maximum allowable amount on a single tooth in the same period of treatment.
(3) Only one restoration for a mesial or a distal lesion is reimbursable, even though a buccal or a lingual approach is used.[2]

The above definition from the Massachusetts Medicaid Dental Provider Manual is of a Class III composite which has been incorrectly defined as one restoration. The definition is both unclear and confusing in that the class III composite is usually a 2 or 3 three surface restoration. Below, in Florida's Childrens Dental Services Manual HRSM 230-22 the same incorrect definition for the Class III Composite restoration is nearly identical to that which has been found in the Massachusetts Medicaid Dental Provider Manual.

Florida HRSM 230-22 page 4-3.
c. Acrylic and Composite Restorations.
(1) Composite resin restoration are reimbursable only for anterior teeth and the buccal surfaces of the first bicuspids.
(2) *Only one restoration for a mesial or a distal lesion is to be billed, even though a buccal or a lingual approach is used.*[3]

Notice below how the Maine Manual defines the class III composite incorrectly.as a one surface restoration and in fact in Florida the above definition is enforced as a one surface restoration. (FDHRS v Clement testimony Morine Funderburk):

Maine Medical Assistance Manual Chapter 11, section 25 Dental Services page 6 dated 9/1/86. 25. 03-3 *Restorative Services (Codes D2000 - D2999)* (Cont.)

B. Composite Resin Restorations

1. Composite resin restorations are reimbursable only for permanent anterior teeth and the buccal surfaces of the maxillary first bicuspids.

2. *Only a one-surface restoration for a mesial or a*

> *distal lesion is reimbursable, even though a facial or a lingual approach is used.*[4]

Now observe what happens in the Wisconsin Dental Medicaid Program Provider Manual. It begins to correct previous known definitions which were erroneous:*

Wisconsin Medical Assistance Provider Handbook, Part B Dentist, Issued 07-82, page B2-011 109.3-B. *COMPOSITE*

Considerable confusion has existed over billing procedures for composite restorations. Therefore the following policy has been adopted by the program:

> A cingulum, incisal, Class V restoration or an interproximal cavity where access is *not* gained from either the facial (labial) or lingual shall be billed under code 02310 (examples: F,L,M,D,I)
>
> A Class III restoration where access is gained from either the facial (labial) or lingual shall be billed accordingly under the code 02320 (examples: ML,DL,MD,DF).
>
> A Class III restoration where access is gained from either the facial (labial) or lingual or any combination of three or more surfaces *except the incisal angle* shall be billed accordingly under code 02330 (examples: MLDF,MLF,DLF,MLD,MFD).[5]

It is difficult to understand how any dental consultants and dental organizations knowledgeable in the field of dentistry could have ever approved any of these three Manuals. Equally difficult to understand, is how, The Boards of Dentistries in these three states, Florida, Massachusetts and Maine did not recognize and could have permitted serious flaws in dentistry to exist in their medicaid dental programs. The following definitions for surgical extractions listed below were found in the Florida, Maine and Massachusetts Dental providers manuals and further emphasize the point that serious flaws in definition are an *imminent danger* to the medicaid dental patient.

Oral Surgery: May be hazardous

Similarities in the same procedure definitions being incorrectly defined in the states of Florida, Massachusetts, and Maine Medicaid Dental Provider Manuals were especially troublesome in the areas of oral and maxillofacial surgery. The extraction of a single tooth which was incorrectly defined as a simple extraction by the closed method or "forceps only technique" and surgical removal of an erupted tooth was the removal of any erupted tooth by the "open method" [both definitions which are not found anywhere in modern dentistry]. The Dental Survey of America team also uncovered where there was conspicuous errors of definitions or dental policy and procedures in Florida's Medicaid Dental Providers Manual, it seemingly had been corrected in the Massachusetts and Maine Medicaid Dental Provider Manuals, example:

Florida Medicaid Dental Handbook HRSM 230-22 October 15, 1981 section 4-12 *Oral Surgery* page 4-7.

> Simple extraction is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extractions can be performed as necessary. HRS will investigate an unusual number of simple extractions in the *primary dentition* to ensure that a significant health service has been performed.

Commonwealth of Massachusetts Medical Assistance Program Provider Manual Series Dental Manual 11/29/79 page 4-15.

> Simple extraction is the removal of a permanent or deciduous tooth by the closed method of "forceps only" technique in which a flap is not retracted. All simple extractions may be performed as necessary. The Department may investigate an unusually heavy use of extractions in the *primary dentition* to ensure that significant health service has been provided.

Above, the words primary dentition(s) from the Florida and Massachusetts Dental provider manuals have been underlined. Note the grammatical errors and note the use of the term "forceps Only." Now notice below the subtle changes in the Maine Dental provider manuals as the reference to the primary dentition has been eliminated.

Maine Medical Assistance Manual Dental Services 9/1/86, page 9.
25.03-7 *Oral Surgery (Codes D7000-D7999)*

> *A. Exodontic Services*
> *1. Simple Extraction*
> Simple extraction is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extraction may be performed as necessary. The Department may investigate an unusually heavy use of *extractions* to ensure that a significant health service has been provided.

Any tooth, no matter how easy the extraction may appear, has the potential for complications. The use of the term simple extraction is both inconsistent and incorrect with the current practice of dentistry. The term is single extraction American Dental Association (ADA) billing procedure code 07110, which all 3 manuals use with exception of Florida where the term is described as the extraction of the first tooth in quadrant. In Florida, both the procedure definition and the procedure code are incorrectly defined. Massachusetts and Maine both use the term simple extraction incorrectly as their procedure definition, but correctly use the term single extraction in their ADA billing procedure code 07110.

In both the Florida, Maine and Massachusetts Medicaid Dental Provider Manuals the definitions for the Surgical extractions were found to be so flagrantly incorrect to the point that each State's Dental Program Manuals has committed either the exact, identical technical or grammatical errors example, the Florida Program (extract or section of a tooth) of which only the grammatical error had been corrected in the Maine and Massachusetts Medicaid Dental Providers Manual (extraction or the sectioning of a tooth).

Florida HRSM 230-22, Page 4-7, October 15, 1981

Surgical removal of an erupted tooth is the removal of

> any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section of a tooth.

Commonwealth of Massachusetts Dental Manual Page 4-20, November 29, 1979.

> Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of substantial amounts alveolar bone in order to extraction or the sectioning of a tooth.

Maine Medical Assistance Manual, Dental Services Page 9, September 1, 1986.

> Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of substantial amounts of alveolar bone in order to effect the extraction or the sectioning of a tooth.

The Massachusetts and Maine Medicaid Dental Program Manuals are so bad that they both go on to reference the open method technique on all of the extractions for impacted and unerupted teeth. The open method of extraction is a procedure method of extraction which is not known in dentistry or to the training of the modern dentist. R.J. Fonseca DMD, chairman department of oral maxillofacial surgery university of Michigan states:

> "the reference of differentiating between open and closed extraction is too simplistic and does not reflect real clinical practice."[1]

The *Oral and Maxillofacial Surgery Procedural Terminology* manual of the American Association of Oral and Maxillofacial Surgeons descriptions for impacted teeth was readily available to anyone for free at 211 E. Chicago Ave., Chicago IL 60611 (312) 642-6446.

Oral Surgery: Alveoloplasty and The Reshaping of Justice

The most frequently performed procedure in pre-prosthetic surgery is alveoplasty.[8] Any surgery performed on the alveolar process can be considered pre-prosthetic surgery.[9] It is well known that the Criminal Justice System does misrepresent the rights of poor people, who otherwise cannot afford legal representation. Yet, surprisingly the same can be said about the dentist accused of medicaid fraud in which lawyers have no understanding about the field of dentistry. This section shows the inherent weakness of an administrative hearing officer, and state court judge, who found a dentist guilty for doing dentistry. In their decisions Leon County Judge Charles McClure and administrative hearing officer William R. Cave overturned every piece of scientific dental research including journals and textbook publication used in the field of dentistry. The following is a summary on how illogical medicaid policies nearly cost one dentist his freedom and how the same policies are an imminent danger to the public.

From: HRSM 230-22 p.p. A1-5-5, **(FLORIDA)** the procedure Alveoplasty is listed by dental procedure code 07310 and 07320 as Alveolectomy which is incorrect. (see ADA procedure codes)

> October 15, 1981, HRSM 230-22, Childrens Dental Service Florida Medicaid.
>
> 07310 *Alveolectomy*, per quadrant, *in conjunction* with extractions.
>
> 07320 *Alveolectomy*, per quadrant, *not in conjunction* with extractions.
>
> 07350 *Stomatoplasty*
>
> *Any surgery performed on the alveolar process can be considered pre-prosthetic surgery. The subject matter in this chapter is concerned with those surgical procedures, which are most intimately related to the ultimate wearing of dental prosthetic appliance. A dental prosthetic appliance would include a complete denture, a partial denture or a fixed bridge.*

From: Testimony of Marie Funderburk, Glen Stone, Irving Fleet DDS., administrative hearing Florida case 86-3023, Florida Department of Health and Human Services (HRS) v Dr. C.

15. It was determined that Dr. C. filed an excessive number claims for alveolectomies. Dr. C. received payment for 117 alveolectomies performed on 52 children.

The principles of pre-prosthetic surgery frequently are ignored. Dentures are inserted on residual alveolar ridges that are too sharp, that have bony undercuts, or have inadequate vestibular heights or depths. Successful prosthodontics therapy depends on successful and carefully planned pre-prosthetic surgery.[6]

From: Hearing case 86-3023 *Florida Department of Health and Human Services* (HRS) v *DR. C.* and HRSM 230-22.

HRSM 230-22 at paragraph 4-12 i states. "Alveolectomies are indicated only on extreme cases without which insertion of dentures or partial would be impossible."**

The most frequently performed procedure in pre-prosthetic surgery is the alveoplasty. Of all of the procedures in minor oral surgery perhaps none is as demanding. As with any surgery, the results cannot be evaluated until healing has taken place. It is surprising to see the wide variation of results, which would seem to indicate that performing a satisfactory alveoplasty is a good indication of one's surgical skill.[6]

From: *Florida Department of Health and Human Services (HRS) v DR. C.* case no 86-3023.

It is standard dental practice to perform *alveolectomies (a reshaping of the bone)* only where a denture is supplied.

Until the last decade, the procedure most commonly performed was referred to as *alveolectomy*. Interpreted literally, this term means the surgical removal of part or all of the alveolar process. The term *alveoplasty* is used since it better describes the minimal reshaping of the alveolar process.

Alveoplasty includes the excision of bony projections and undercuts followed by minimal recontouring of the alveolar process. It is performed to facilitate removal of teeth, to correct irregularities of the residual alveolar ridge following removal of one or more teeth, and to

> prepare the residual ridge for the reception of dentures. The principle goals of alveoplasty are the proper contouring of the alveolar process and the preservation of as much alveolar bone as possible.**

From: Florida HRS v. Dr. C. case no. 86-3023.

> Performing an alveolectomy *on a child is not a common practice* and there was no indication that Dr. C performed the procedure in preparation of insertion of partial or dentures as required by HRSM 230-22.

**(note below that alveoloplasty in Illinois is felony fraud in Florida)

From: Illinois Medical Assistance Program. Section II, Chapter D-200, Dental Services.
D-210 COVERED SERVICES, February 1987, II-D-8

D-217-2 Alveoloplasty

> Alveoloplasty is a covered service *only for children.* Prior approval is required for alveoloplasty as a separate procedure. Study models are to be submitted with the prior approval request.**

From: October 6, 1987, Before the Honorable Charles D. McClure, Circuit Judge SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA case no. 86-3023.

THE COURT:

> On 97 occasions you filed claims for extracting more than one first tooth, which was apparently against procedure. On 117 occasions you received payment for reshaping of the bone—cannot pronounce the word here-performed on 252 children, which in the finding of the administrative officer was excessive.**

**(note below that alveoloplasty in Illinois is felony fraud in Florida)

Labial and Buccal Cortical Alveoloplasty: This the most common form of alveoplasty, performed to a certain degree following almost all multiple extractions. It is simply reshaping the alveolar process by removing labial and buccal undercuts and all sharp and rough bony projections.

Certainly, in other branches of restorative dentistry, no one would consider inserting an inlay into a cavity that has not been precisely prepared or delivering a fixed partial denture without a carefully planned path of insertion. It is inconceivable to assume that a full denture is the one type of dental restoration for which the mouth is already perfectly designed!

From: *Wisconsin Medical Assistance Provider Handbook* Part B Dentists, III. Other Service Limitations, Issued 07-82, Page B3-005

E. NON-COVERED The following services are not a covered benefit by the WMAP:

13. Alveoloplasty and stomatoplasy.

It is nearly impossible to believe how any dental consultants to the Wisconsin Medicaid Program could have ever allowed this manual to go into services without including alveoplasty as a procedure for payment in provider services. Dental Survey of America found that the common dental procedure alveoplasty, varied so widely that what is the standard practice of performing the alveoplasty learned by most dentists during their dental school training is a felony fraud in most state run Medicaid Dental Programs.

Finally in summary alveoplasty is described as a very important procedure performed following nearly all extractions whether it is one tooth or multiples of teeth.

In performing an alveoplasty, a few general points should be kept in mind:[6]

1. The ideal ridge is U-shape.
2. A V-shaped ridge is to be avoided.
3. Most undercuts are undesirable.
4. The ridge need not be perfectly smooth.
5. All sharp bony edges should be removed.
6. Large prominence should be reduced.
7. More conservation is warranted in younger patients (who will be wearing dentures longer)

The Dentist In Court

Unfortunately for the dentist, there are very few lawyers who have a good understanding of dentistry or the complexity of dental procedures and procedure codes. This very serious problem could likely be traced to the discernment most people would have in a general population when concerning the field of dentistry. This author has found in his practice that a significant majority of patients that he treats are more cognizant of childbearing, hypertension, and the common cold than they are about dental decay, periodontal disease; even more importantly what the dentist does and how the dentist treats these conditions and lawyers are no different. Ask a lawyer or a child what a dentist does and their most likely response is that they fill and pull teeth.[6]

It may cost a dentist around $65,000 to $100,000, for four years of general dental training at the average dental school in America; but in order to receive justice the dentist must spend $50,000 to hire an attorney in which most of the legal time is being used up teaching dentistry to the lawyer. Therefore, what is happening in Florida and throughout America is that the *plea of No Contest* has become the plea that the dentist cannot afford his/her day in court. Thus errant illegal illogical medicaid policies are reenforced by the State and Administrative Court Judges; medicaid recipients are then subject to dental practices which are an *IMMINENT* danger to their well being. The field of dentistry as well as the dentist are disgraced by unenlightened State Circuit Court Judges, who have found dentist guilty for practicing sound dentistry.[7]

Conclusion

Recently, in America a product, which was mislabeled because it supposedly did not contain apples, sent several executives of one large company to prison. The so called Pentagate Scandal deals with defense contractor consultants who bribed government officials to gain access to information which undermined the bid process for the sale of military equipment and it is alleged that some of the equipment was defective. Although Dental Survey of America has found no evidence whatsoever of any Medicaid official being bribed, we have found evidence which appears to strongly suggest that Medicaid officials in Florida and several other states had deliberately designed medicaid dental manuals to be substandard and defective.[8] Thus, these Medicaid Dental Provider Manuals are an *imminent danger to the health care of poor Americans.*

Dental Survey of America's review of the Florida Medicaid Dental Provider Manual such that this manual should be banned in the State of Florida. We feel that the Florida Dental Association, Florida Medical, Dental and Pharmaceutical Association and the Florida Board of Dentistry should disassociate themselves from the Florida Medicaid Program. Our rating of this Program is minus 100(-100).

All correspondence should be sent to Dr. Clement, Dental Survey of America, P.O. Box 13328, Tallahassee, FL 32317-3328. Drs. Williams and Sanders may be reached at the same address.

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ARE MEDICAID FRAUD CONTROL UNITS THE REAL FRAUD ?

PART-1

STUDY BY DENTAL SURVEY OF AMERICA ON MEDICAID DENTAL FRAUD

NORMAN J. CLEMENT, DDS
DARYL E. WILLIAMS, DDS., MS
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INTRODUCTION

On October 25, 1977, the Congress enacted legislation authorizing a fraud for unit every jurisdiction operating a Medicaid program. The fraud units are responsible for investigating health care providers who commit fraud and abuse in the Medicaid programs. When the Congress enacted this legislation, it was concerned that sufficient efforts were not being made to control Medicaid fraud.[1] This study was prompted as the result of a growing number of dentists having found themselves under indictment on charges of medicaid dental fraud for dollar amounts of less than $500.00 by these fraud units. We reviewed the investigation methods and tactics used by fraud units to obtain indictments against dentists and other health care providers. We also reviewed the training, qualifications, and backgrounds of investigators assigned to Medicaid Fraud Control Units.

DISCUSSION

In January of 1988, a group of dentists formed Dental Survey of America and began a comprehensive comparative study of our nation's Medicaid Dental Program.[2] Dental Survey of America obtained copies of some 46 State medicaid dental program manuals and compared whether policies and procedures in these programs and manuals were consistent with Dental Health Care policies established by the federal government and national organizations.[3] Dental Survey of America began to identify two very distinct interrelated problems with the medicaid dental program:

> 1. In several programs, policies and procedure definitions were inconsistent with the nomenclatures used in modern dentistry and some procedure definitions were found to be incomplete or otherwise incorrectly based on current accepted dental practice.[4]
>
> 2. Many investigators assigned to Medicaid Fraud Control Units are neither competent, knowledgeable nor qualified in the area of health specialties they are designated to investigate and oftentimes use outdated, outmoded policy and procedure manuals for the interpretation of provider fraud and abuse.

Under the medicaid program, the federal and state governments share the cost incurred by states in providing medical care to persons unable to pay for such care. This program authorized by title XIX of the Social Security Act, began in 1966. Each State's Medicaid agency is responsible for designing and administering its program.[5]

In some programs Medicaid officials had uniquely designed policy and procedure manuals which made no sense and made it nearly impossible for any dental providers to be reimbursed for their services. Arbitrary decisions, often not in the patient's best interest are made by public health dental consultants whose individual opinions are not easily challenged.[6] It has become evident that medicaid clearly is a program operating outside the practice of modern dentistry and in all but a few states, local Dental Organizations and Boards of Dentistry; had very little input in the final policies written for State-run Medicaid Dental Program Manuals.[7]

Medicaid Policy Review Boards and Committees required by Early Periodic Screening Diagnosis Treatment (EPSDT) legislation to review Dental Policies as set forth in program manuals were found in several states to be ineffective or non-existent. On June 24, 1986 at the 90th annual convention of the Florida Medical, Dental and Pharmaceutical Association, several dentists requested to serve on the committee responsible for writing the Florida medicaid dental manuals. Morine Funderburk, Program Policy Director for the Florida's Medicaid Program, Department of Health and Rehabilitative Services **(HRS)** gave the following response:

> " We don't have a Committee now, what we have is a loose sort of ***thing*** between this consultant here and that consultant there. There has been talk about a committee but we haven't gotten around to that sort of thing yet."[8]

However Federal Medicaid EPSDT regulations requires under 42 CFR SECTION 441.56 (b) (2) 1985 that:

> ...states consult appropriate professional organizations in the development of schedules for periodic visits and within them screening packages.[9]

The intent of this requirement was to ensure that states fashioned EPSDT-Medicaid programs which reflect reasonable standards of dental and medical practice.[10]

Dental Survey of America found that the training received by fraud investigative personnel consisted of either on-the job training (with no medical or dental backgrounds) or a three to seven day training course sponsored by municipal organizations. We found fraud units relied heavily on policies in program manuals and opinions of public health dental consultants. Program manuals, policies, and procedures were found to be so technically flawed that no case of medicaid fraud should have or could have been brought against any Dental Medicaid provider in some states. According to James R. Hayward DDS, MS, University of Michigan Emeritus Professor and Chairman Department of Oral & Maxillofacial Surgery "It is quite obvious that no self-respecting dentist could ever conduct their practice at the dictates of medicaid." [11]

ARE MEDICAID FRAUD CONTROL UNITS THE REAL FRAUD?

In congressional testimony before the House Appropriations Committee and Senate Special Committee on Aging, several Medicaid Fraud Control Units had reported that once providers became aware of ongoing investigations on them or other providers in the same geographic area or provider specialty, their Medicaid billings decreased. The analysis included a review of changes in providers' Medicaid billing patterns or changes in Medicaid payments to providers as indicators of deterrence before, during, and after fraud units investigations.[12]

Dental Survey of America uncovered serious evidence indicating that many fraud units utilized investigative methods, tactics, and statistical analyses that were questionable and possibly illegal. Moreover our study clearly established that much of the exhortations made by fraud unit's regarding their deterrent effects have been grossly overstated and possibly erroneous.

Providers frequently verified that their first realization of an investigation occured when fraud units began to harass and intimidate patients and employees affiliated with their operation.[13,14,15,16,17] Several Florida Dentists reported frequent calls from patients complaining of visits to their homes and jobs by fraud investigators. These patients reported having been told that their dentist was engaging in fraudulent activity, and these same investigators were encouraging their patients to find another dentist.[18,19,20] One Dentist also reported to us that one of his former denture patients had called his office and stated she was approached by fraud investigators in her yard and asked to remove her denture.[21] This Dentist stated, "I noticed a significant drop in patients on medicaid making appointments with my office."

LETTER OF INTIMIDATION

Some tactics employed by fraud units included the use of letters of intimidation directed against the targeted establishment.[22] The State of Michigan has effectively used this technique. Dental Survey of America received information obtained on discovery by Attorneys representing a large medical laboratory under investigation by the Michigan Attorney General's Office of Medicaid Fraud. In 1984 tho State of Michigan reported Quality Clinical Laboratory (QCL) was the highest paid provider under its medicaid program receiving a total of $2 million dollars from the state coffers in that same year. Michigan Attorney General Frank Kelly and his investigators involved in this case sent over 300 letters to Physicians who had accounts with QCL before their actual investigation took place (see Figure 8.1). The form letter stated:

Dear Dr.________:

It has come to our attention after a review of your past billings that you may be billing or causing billing to the Medicaid Program for laboratory test which are not necessary for the diagnosis and treatment of your Medicaid patients........This practice cannot be tolerated by the Medicaid Program. If you or one of your colleagues have engaged in this practice, you are encouraged to cease immediately and contact this office to set up a conference to discuss this matter..........A physician who orders unnecessary laboratory tests from a laboratory may be in violation of Section 7(2) and subjects himself/herself to a 4 year felony and/or $50,000.00 fine.........The Attorney General's Medicaid Fraud Unit intends to strictly enforce Section 7 of the Medicaid False Claims Act. Where Attorney General investigators observe billings of laboratory"profiles" on Medicaid patients, the referring physician to the laboratory can be prosecuted.

The last paragraph of the letter concluded with an invitation for physicians to call in and discuss the above matter with Fraud Unit Investigators.

> "I invite you to call the Medicaid Fraud Unit to set up a conference, if you wish to discuss the new provision in Section 7 of the Medicaid Fraud Act. The telephone number for the Attorney General Medicaid Fraud Unit is (517) 373-3800 or 373-8455. You may contact Patrick J. O'Brien or Richard Ervin."[23]

Physicians who called in were told specifically that "they had no need to worry because the Medicaid Fraud Control Unit was conducting an investigation of Quality Clinical Laboratories." Within two weeks of receipt of this letter, 150 physicians had completely closed their accounts or had stopped sending any laboratory work to Quality Clinical Laboratories. Several physicians stated in their depositions that they were specifically told by Medicaid Fraud investigators to discontinue sending any of their laboratory work to QCL; and there was no doubt in their minds that if they continued doing business with QCL, they too would be subject to prosecution.

The owner of QCL stated that the effect on his business was devastating. It went from a multi-million in gross yearly sales to less than one million dollars within one year. The owner also stated that as the result of this action, his business was then **forced into bankruptcy** and he had to cut **165 of 200 employees from his payroll**. After a 10-year investigation, which cost the State of Michigan Attorney General's Office over 5 million dollars, QCL was later charged with $3,000 (three thousand dollars) in medicaid fraud and $47,000.00 dollars in a scheme to defraud medicaid of services over a 10 year period. During the same 10 year period QCL had grossed over $70,000,000 (70 million) of which $15,000,000 (15 million) were earned from Medicaid related services.

The Office of Inspector General (OIG) for the Department of Health and Human Servcices (HHS) concluded that Medicaid Fraud Control Units (MFCU's) represent a strong deterrent to fraud, waste, and abuse at the state level that could not be duplicated by the OIG if the units did not exist.[24] Many health experts and health care providers involved with medicaid agreed on one thing " One sure way of wiping out medicaid fraud and abuse is to wipe out all of the providers."

(attached letter)

Dear Dr._______:

It has come to our attention after a review of your past billings that you may be billing or causing billing to the Medicaid Program for laboratory test which are not necessary for the diagnosis and treatment of your Medicaid patients. Chapter I of the Medicaid Practitioners Manuals prohibits services that are not medically necessary in accordance with professionally recognized standards. This practice cannot be tolerated by the Medicaid Program. If you or one of your colleagues have engaged in this practice, you are encouraged to cease immediately and contact this office to set up a conference to discuss this matter.

You should be aware that effective December 26, 1984, the Medicaid False Claims Act was amended to include the following provisions:

> "Sec. 7.(1) A person shall not make or present or cause to be made or presented to an employee or officer of this state a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, as amended, being sections 400.1 to 400.121 of the Michigan Complied Laws, upon or against the state,knowing the claim to be false.(2) A person shall not make or present or cause to be made presented a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, which he or she knows falsely represents that the goods or services for which the claim is made were medically necessary in accordance with professionally accepted standards. Each claims violating this subsection shall constitute a separate offense. A health facility or agency shall not be liable under this subsection unless the health facility or agency, pursuant to a conspiracy, combination, or collusion with a physician or other provider, falsely represents the medical necessity of the particular goods or services for which the claim was made. (3) A person who violates this section is guilty of a felony, punishable by a fine of not more than $50,000.00, or both." (Emphasis added)

A physician who orders unnecessary laboratory tests from a laboratory may be in violation of Section 7(2) and subjects himself/herself to a 4 year felony and/or $50,000.00 fine. The Legislature believes that medically unnecessary services charged to the Medicaid Program has become such a problem that the above severe penalties are necessary to discourage this activity. The Attorney General's Medicaid Fraud Unit intends to strictly enforce Section 7 of the Medicaid False Claims Act. Where Attorney General investigators observe billings of laboratory"profiles" on Medicaid patients, the referring physician to the laboratory can be prosecuted.

This letter is not intended to unnecessarily alarm you, but rather to inform you of the above-referenced provision which has been embodied in the Medicaid False Claims Act. This "medical necessity" provision should not change the practice of the vast majority of Medicaid Practitioners. This provision will hopefully affect the practice of that small number of doctors who perform unnecessary services and/or order unnecessary laboratory services.[25]

I invite you to call the Medicaid Fraud Unit to set up a conference, if you wish to discuss the new provision in Section 7 of the Medicaid Fraud Act. The telephone number for the Attorney General Medicaid Fraud Unit is (517) 373-3800 or 373-8455. You may contact Patrick J. O'Brien or Richard Ervin.[26]

(Fig 8-1)

QUALIFICATIONS

Documents obtained under the freedom of information act on studies from the United States General Accounting Office showed that in fiscal years1984 and 1985, federal and state expenditures for Medicaid Fraud

Units totaled about $43 million and $47 million , respectively. The federal share of the units' total expenditures was about $32 million or 75 percent in fiscal year 1984, and about $36 million or 76 percent in fiscal year 1985. Of the 33 fraud units in operation in fiscal year 1984, 28 received 75-percent federal and 25-percent state funding. The other five units received 90-percent federal and 10-percent state funding. Of the 36 units in operation in fiscal year 1985, 28 received 75-percent federal funding and eight received 90- percent federal funding.[27]

Despite the enormous amounts of funding that Fraud units are allocated by the Federal Government, we found no uniform standard for training of medicaid fraud investigators. One such example Dental Survey of America found was that investigators with Florida's Office of Auditor General Medicaid Fraud Control who are given a three day training program sponsored by the Council of State Governments known as CLEAR. CLEAR is an acronym for Clearing House on Licensure, Enforcement and Regulation. Several medicaid fraud investigators then stated in depositions that their only working knowledge of Dentistry instruction came from supervisory personnel as the result of on the job training. Other Florida fraud investigators admitted their investigations were influenced solely by a single public health dental consultant who was on loan to their department.

DEPOSITIONS

The following depositions present a classical example of how unsuitably trained investigators were instrumental in obtaining the indictment of one Florida dentist. Glen Stone, medicaid administrative fraud investigator with Florida's Department of Health Rehabilitative Services (HRS), was deposed by Mr. David Barrett, attorney for the opposing side:[28] Edward Youngblood, Special Agent in-charge of daily activities for the Medicaid Fraud Control Unit in the State of Florida, who has been involved in over 40 cases against Dental Medicaid Providers, deposed under oath for purposes of discovery.

DEPOSITION OF GLEN STONE:

> Q. What is your current occupation?
>
> A. I am a Human Service Analyst for the Medicaid Office, Program Integrity, Department of Health and Rehabilitative Services.
>
> Q. For how long have you held that position?
>
> A. A little over one year.
>
> Q. What did you do previous to that?
>
> A. ***I was a personnel technician*** with the Department of Health and Rehabilitative Services Program Headquarters office.

Q. What does a Human Service Analyst do?

A. My particular position, that is a generic title. My particular position does ***administrative investigations of Medicaid Violations***.

Q. What qualifications do you have to be and investigator?

A. I have completed the CLEAR training.

Q. What is CLEAR training?

A. I'm not quite sure exactly what the acronyms means. Something like certified--it escapes me. I can't remember.

Q. Who provided the training?

A. The CLEAR Association.

Q. When did you take this training?

A. In September of this year(86).

Q. Previous to September of this year, you had had no training in any investigation?

A. ***I had on-the-job training.***

Q. Who trained you?

A. My supervisor, Mr. Ken Mcloud initially, Mr. Robert Pierce actually was the supervisor of the office......Oh , one other thing I forgot to add. There is a two-week introductory training that anyone take who comes into the Medicaid program which basically covers the scope of the Medicaid Program, all of the different programs such as hearing services, visual services, whatever.

Q. What training did Mr. Pierce provide?

A. I remember he discussed the tracking system, which is basically how we keep track of the cases, and if my recollection is correct, he included a lecture on the basic legal status of our office.

Q. What is the basic legal status of your office as you were trained by Mr. Pierce?

A. Well, he was covering, I believe it's Title 19, Social Security Act. The Social Security Act which covers why we have the Medicaid Program, and specifically Florida Statute 409--- I think it's 226.226, and our legal basis of why we can conduct Medicaid investigations.

Q. What training did Mr. McCloud provide you as an investigator?

A. various aspects of things that are in the policy manuals, although I couldn't tell you specifically what, what date or anything like that.

Q. When you say policy manuals, what are you referring to?

A. Such as ***HRSM 230-22***, which is the dental policy manual or the visual services manual or the hearing services manual or any of the program manuals we would deal with, depending on the investigation.

Q. And what aspect of the Children's Dental Service Manual did Mr. McCloud teach you about or train you in?

A. I couldn't answer that question. I couldn't tell you specifically which aspect.

Q. Can you think of any?

A. One that comes to mind is alveolectomies are not allowed in the Children's Dental Service Program.

Q. Mr. McCloud told you that?

A. Yes.

Q. Did he point out any particular section of the manual?

A. Yes, he did........I believe that 4-12. Let me get my manual out. Okay. That would be 4-12, right, item i., alveoloplasty.

Q. Did Mr. McCloud point you to any other written document that he pointed out to say that alveolectomies are not allowed in Children Dental Services?

A. No. Sir.

Q. Now, do you know the difference between an **alveoloplasty** and **alveolectomy**?

A. They are one and the same from my understanding.

Q. So, in your investigation, you treat them as identical procedures?

A. YES.[29]

The term **Alveolectomy**[30] means the surgical removal of part or all of the alveolar process. The term **Alveoplasty** [31] describes the minimal reshaping of the alveolar process. The principle goals of alveoplasty are the proper contouring of the alveolar process and the preservation of as much alveolar bone as possible.

DEPOSITION OF EDWARD YOUNGBLOOD

Q. When you came with the Auditors General's Office in '74, what type of investigation did you do?
A. Investigation into public assistance fraud, which would include **Aid to Families with Dependent Children** or **welfare fraud, food stamp** fraud pg 4.

Q. And then approximately what, three years ago?

A. In 1980 there was a new division formed, the Medicaid Fraud Control Unit...and at that time I was laterally transferred as an investigator from public assistance fraud to the Medicaid Fraud Division.....The title was change from investigator to special agent........I am a criminal investigator.

Q. What is your background by education or training as an investigator?

A. I have a B.S. degree in management from the University of North Florida. I spent---this taxes my memory here-- approximately 12 years active duty in the U.S. Navy and during most of that time I was a squadron or unit legal officer. In that capacity I served both as trial counsel, defense counsel and court -marshall and a special investigating officer.

Q. Are you a lawyer?

A. I am not a lawyer in a civilian sense. I am a graduate of the Naval Justice School, which if you will, is the Navy's version of that. It was prior to the inception of the JAG Court for the Navy. Since that time I left active duty in the Navy in May of 1974 and the same day went to work at the Office of the Auditor General........And since that time I have been an investigator or special agent with the Medicaid Fraud Control Unit. I have had the Florida Minimum Standards training. I am a certified police officer, although inactive......And I am a nationally certified investigator by **CLEAR**, which is the Clearing House on Enforcement and Regulation. It's sponsored by the Council of State Governments. It's a training program put on for primarily investigators in white- collar crime and regulatory-type agencies. Beyond that it would be--

Q. That's, what, a three day course you took from them?

A. No, that's a one week course with an exam.

Mr. Youngblood was further deposed by Mr. David Barrett concerning whether his departments used a dental consultant during their investigation.

Q. Who is your dental consultant?

A. Dr. Charles Kekich

Q. The same guy that works for HRS?

A. That's correct.

Q. What is the purpose in having Dr. Kekich evaluate recipients?

A. I'm not a dentist.

Q. I didn't ask you what he did, I asked what was the purpose in having Dr. Kekich evaluate recipients?

A. To examine them ?

Q. Yes.

A. Because he is a dentist and if there is something that would require that type of expertise, for example, say whether a tooth had two surfaces

> filled rather than three surface filled, that would be a type thing that he would examine. And in his opinion I guess as a dentist, he would say this is what he found.
>
> Q. As an investigator do you consider him a independent evaluator when he is employed by HRS and the Auditor General's office?
>
> A. He's not employed by the Medicaid Program.
>
> Q. I thought you said he was your---
>
> A. Our consultant?
>
> Q. Yes.
>
> A Yes, he is.
>
> Q. Is he HRS's consultant?
>
> A I don't know. He works for HRS but in a different department. So,--
>
> Q. Does he work for the Auditor General's office?
>
> A. No, not in the sense of being an employee of ours. He is a consultant. He is I guess the word I want to use, I don't know of that's correct, **he is on loan** to us when we need that type expertise by HRS.

To our dismay, Dental Survey of America found that the poor backgrounds and substandard training of both Mr. Stone and Mr. Youngblood are typically the norms for Medicaid Fraud Investigation personnel throughout the country.

Unfortunately, Mr. Stone is still currently employed with the Florida Department of Health and Rehabilitative Service in a even more expanded capacity as an investigator. Since 1986 Mr. Stone's investigation techniques have been responsible for indictments against more than 10 health care providers. A check with Florida Department of Law Enforcement (FDLE) special agent Leon Lowery confirmed that Mr. Ed. Youngblood was a certified police officer, although inactive. Special agent Lowery stated that Mr. Youngblood does not meet the minimum standards for criminal investigators in the State of Florida, and his agency does not recognize CLEAR.

WHAT IS CLEAR ?

The National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR) is an organization composed of state officials and administrators involved with occupational licensing and regulation issues.[32] CLEAR was formed in 1980 to facilitate communication on matters of common concern to licensing board members and administrators, central agency administrators, legislative staff, and others in the occupational regulation community.[33]

In order to promote professional standards among regulatory investigators, CLEAR, in conjunction with the Law Enforcement Training Institute, University of Missouri- Columbia, offers a 21 hour training program called NCIT (National Certified Investigator Training Program) in investigative procedures and techniques.[34] The program is held at different sites across the country each year. Both **novice** and **experienced** regulatory investigators and enforcement administrators can attend and benefit.

The curriculum is a generic one covering topics investigators must know to successfully conduct regulatory investigations. The curriculum material is geared to entry-level investigators.[35] The session ends with an examination. A minimum passing score on the exam of **70%** is necessary before CLEAR certification is granted. Certification is also dependent upon one year's experience as a state regulatory investigator.[36] DSA contacted Bill Stephens, Assistant Professor, Law Enforcement Training Institute, University of Missouri-Columbia, (314) 882-6021, and he stated that the certificate was only for attending the class and taking the test.[37] He states the (NCIT) does not certify investigators.

In April 1986, the Office of Inspector General (OIG) proposed three new rules to increase units' effectiveness. Two of the three rules are on unit staffing levels. The third is on staff training.

1. Units must have at least five professional staff members upon initial certification unless the OIG waives this requirements.
2. Units must maintain a minimum ratio of 2 to 3 investigators for each attorney on their staff.

In addition to these two rules, the OIG is proposing that "All Medicaid Fraud Control personnel must receive basic training in 'White Collar Crime' and Medicaid program regulations."[38]

IN THE BEGINNING OF EVERY PROVIDER AGREEMENT THERE IS A CONTRACT WHICH HAS BEEN BREACHED!!!

Federally funded State-run medicaid Programs usually consist of three separate but loosely connected agencies whose interpretations of basic dental procedure are frequently in conflict with each other.

1. **The fiscal agent** - oftentimes is a private corporation under contract with the State Agency which receives and processes medicaid claims *using regulations and guidelines established by the State agency* and the Federal government.[39]

2. **The State medicaid agency** - responsible for administering the program, writing policy and procedure. The State medicaid agency is generally responsible for the development of Health Care Provider Program Manuals for each individual provider specialty.

3. **The Medicaid Fraud Control Units** - a separate state agency independent of the first two agencies.

Since April 1979, the Department of Health and Human Services office of Inspector General (OIG) has been responsible for the certification, annual recertification, and oversight of fraud units. To be certified, a fraud unit must meet several requirements -- two of which are:

1. an entity separate from and independent of the state Medicaid agency

2. part of the state attorneys general's office or have formal procedures established for referring cases to it. [40]

In order to become a participant in any medicaid program health care providers are required to sign a provider contract agreement. This responsibility usually comes under the State Agency.

Dental Survey of America found that state agency and fraud units in the State of Florida had violated all dental provider contracts. All three units exchange and act upon information provided from each other units, in order to determine if alleged fraud and abuse exist. Therefore, mismanagement by the State Agency in failing to follow federal mandates, adopt administrative rules, along with the erroneus interpretation of standard dental procedure by the Medicaid Fraud Units, lead us to question the integrity of the entire program.

Several Florida Dental and Medical providers complained bitterly that they found themselves investigated, [41],[42] forced into paying recoupments,[43] indicted[44] or being terminated from the medicaid program,[45], [46] on the very information instructed in policy and procedure manuals. Dentists were notified by **certified** letter through the State Agency which were signed by the Deputy Assistant Secretary which stated:

> Dear Dr._______
>
> This is to advice you of your termination for cause from participation in the Florida Medicaid Program for violation of federal and state laws and regulations respecting the medicaid program, effective with the date of this letter subject to your right of appeal as discussed below.
>
> **Information** has been received from the ***office of the Auditor General, Medicaid Fraud Control Unit***, to the effect that you have violated Medicaid rules and regulations.[47]

In Florida's section 5, 7 and 8 of the provider contract reads:[48]

> 5. The Department agrees to notify the provider of any major changes in Title XIX or State rules and regulations relating to medicaid.
>
> 7. The provider and the Department agree to abide by the provisions of the Florida Administrative Rules, Florida Statutes, policies, procedures, manuals of the Florida Medicaid program and Federal Laws and regulations.
>
> 8. This agreement may be terminated upon thirty days written notice by either party. The Department may terminate this agreement upon five days notice in the event fraud, abuse, or failure of the provider to comply with any or all of the provisions of this agreement.

Contract agreements are required by Federal law and policies are generally consistent in every State program across the country. Yet, Dental Survey of America could confirm that of the 46 states reviewed only two (OHIO, GEORGIA) had adopted their medicaid dental program manuals under administrative codes. Florida's HRSM 230-22, page 1-1, states:

> 1-4 Legal Authority.
>
> a. The Florida Medical Assistance Program (Medicaid) as authorized by Title XIX of the Social Security Act, is a joint Federal-State program to provide essential health needs for all persons receiving Public Assistance and certain other persons who do not have sufficient income to provide medical care for themselves.

> b. **This manual is issued in accordance** with Federal Regulations and the Department of Health and Rehabilatative Services Administrative **Rule. Section 10C-7.523, Florida Administrative Code** (F.A.C.) which governs the Medicaid Dental Service Program. Section 409.266, Florida Statues (F.S.) authorizes Medicaid to make dental services available, as described in this manual, to all Medicaid eligible recipients under 21 years of age.

In Florida, the of office The Deputy Assistant Secretary for medicaid is responsible for developing the statewide policies and procedures for the Children's Dental Service Program and for all other services offered under the Medicaid Program.[49] On December 3, 1986 Judy Mitchell then Deputy Assistant Secretary of the Medicaid Program for the State of Florida's Department of Health and Rehabilitative Service stated in deposition for purposes of discovery:

> Q. Do you know how your staff goes about determining whether or not a provider understands the rules of the program for billing when they see a situation that it appears there has been inappropriate billings?
>
> A. Not specifically, no.
>
> Q. Do you know whether you have any rules or regulations to follow up on that?
>
> A. We have detailed rules and regulation on our whole surveillance and utilization review process because that's required by the Federal government. And we are investigated on that each year to determine our compliance with that process. And we were just recently evaluated and we passed. So, from that it tells me that we are doing what the rules and regulation say we are supposed to be doing.
>
> Q. The Federal rules and regulations?
>
> **A. Yes.**
>
> Q. Now, the rules and regulations you have adopted, have they been adopted under the Florida Administrative Code or are these strictly internal policy?
>
> **A. This is the Florida Administrative Code.**[50]

On March 16, 1987 Dental Survey of America contacted then Secretary of State of Florida George Firestone for a search of Florida Administrative Code under section 10C-7.523. Upon reveiwing these documents Dental Survey of America found no evidence that the Florida Medicaid Children's Dental Service manual had ever been adopted under administrative rules in the State of Florida. Dental Survey of America also found no evidence that the State of Florida's program is in compliance with guidelines of Federal EPSDT legislation. Mr. Firestone's certification is as follows:

> I, GEORGE FIRESTONE, Secretary of State of the State of Florida, do hereby certify that pursuant to Rule section 1S-1.005, Florida Administrative Code, relating to Publication by Reference, after search of our records they reflect that the Department of Health Rehabilitative Services Manual HRSM 230-22, Medicaid, Children's Dental Services, is not on file with this office.[51]

Clearly, Florida medicaid officials have failed to adopt its Children's Dental Service Program under Florida Administrative Codes and Procedures. In order for any Rule in any state to have the power of enforcement it must be properly adopted under its state's administrative codes and procedures; or it cannot be enforced as a Rule.

The EPSDT regulation effective January 29, 1985 at 42 CFR 441.56(c)(2) requires, just as the previous regulations did (42 CFR 441.56(b)(2)), that:

> States provide for "Dental Care ...needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," **States will be cited as out of compliance with the regulation** at CFR 441.56(c)(2) unless this service is made available to children (through EPSDT)

Federal regulation 42 CFR 442 .457, .460 and Florida Administrative Code 10D-38. 13(1-6), (8-9). Chart of State and Federal standards in the above area. Specifically requires that States provide:

> Comprehensive treatment services for all clients , which include dental specialties of pedodontics, orthodontics, periodontics, prosthodontics, endodontics, oral surgery, and oral medicine as indicated as well as comprehensive preventive dentistry programs.

The Health Care Financing Administration has broadly interpreted these requirements (Guide to Dental Care. EPSDT-Medicaid. Pub. No. HCFA 24515), and a federal court affirmed the broad intent of this language (Mitchell v Johnston 701 F 2d 337, 5th Cir, 1983).

> "When state voluntarily and knowingly accepts terms of federal-state "contract" state is required to fulfill its mandatory obligation under that contract.[52]"

The celebrated case **Mitchell v Johnston** (**Cite as 701 F.2d337(1983)** affirmed the intent of Congress and the Federal Government to provide quality Dental care to poor children under 21. The findings of the 5th Circuit Federal District Court of Texas and affirmed by the Federal Appeals Court were so broad and so sweeping they made possible comprehensive dental services including Orthodontia available to poor Americans and made it impossible for any State to avoid, frustrate or cut in any form or fashion federally mandated orders as intended by the will of the Congress of the United States of America to such services available under EPSDT.[53]

Almost five years after the Federal Courts ruled in **Mitchell v Johnston** the State of Florida's Medicaid Dental Program officials are still failing in every form and fashion to abide by the provisions of the Florida Administrative Rules, and Federal laws and regulations. Moreover, the State of Florida, as with nearly all other states, has failed to bring its programs into compliance with the Federal Court rulings and federally mandated services.[54]

Therefore, there is overwhelming evidence as to the legal authority of any medicaid fraud unit to enforce state and federal rules and regulations which the State's Medicaid Agencies have failed to adopt and abide by. This poses serious questions as to whether these units and our Federal government may have indicted, mandatorily excluded, fined and incarcerated some medicaid dental health care providers who were otherwise innocent.

CONCLUSION

By enacting legislation which authorizes a fraud unit every jurisdiction operating a Medicaid program, the Congress may have unwittingly created one of America's most clandestine operation. Most Medicaid Fraud Control Units received approximately 75 percent of their annual budget from the Federal Government. Yet, fraud units appear to be improperly trained, poorly supervised, and in some states out of control.

Among the troubling aspects of these Fraud Units is the fact that experts consistently report that health care for poor Americans is bad and getting worse! So, it becomes obvious to the most casual observer that while the administrators of the Medicaid program have **little interest in the welfare of the recipients, they do have an obsessive zeal to persecute providers who serve these recipients**.[55]

States have also failed to inform the medicaid recipients of the conscious decision to employ sub-standard treatment procedures. James R. Hayward DDS., MS., University of Michigan Emeritus Professor and Chairman Department of Oral & Maxillofacial Surgery states:

> "Since the control of funds for the medicaid programs seeks to provide quality service for the most patients for the least money, oral **health care will remain substandard** or token to improve their statistics."[56]

Consequently, Dental Survey of America finds it necessary to demand a General Accounting Office study in order that unrestrained behavior of the Medicaid Fraud Control Investigators can be checked, and the needs of the Medicaid recipients can be met. It is now incumbent upon the Congress to give Oversight on the activities of Medicaid Fraud and Abuse Control Units.

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STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

STANLEY D STEINBORN
Chief Assistant Attorney General

FRANK J. KELLEY
ATTORNEY GENERAL

LANSING
48913

August , 1985

Dear Dr. __________:

It has come to our attention after a review of your past billings that you may be billing or causing billings to the Medicaid Program for laboratory tests which are not necessary for the diagnosis and treatment of your Medicaid patients. Chapter I of the Medicaid Practitioners Manual prohibits services that are not medically necessary in accordance with professionally recognized standards. This practice cannot be tolerated by the Medicaid Program. If you or one of your colleagues have engaged in this practice, you are encouraged to cease immediately and contact this office to set up a conference to discuss this matter.

You should be aware that effective December 26, 1984, the Medicaid False Claims Act was amended to include the following provision:

> "Sec. 7.(1) A person shall not make or present or cause to be made or presented to an employee or officer of this state a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, as amended, being sections 400.1 to 400.121 of the Michigan Compiled Laws, upon or against the state, knowing the claim to be false.
>
> (2) A person shall not make or present or cause to be made or presented a claim under the social welfare act, Act No. 280 of the Public Acts of 1939, which he or she knows falsely represents that the goods or services for which the claim is made were medically necessary in accordance with professionally accepted standards. Each claims violating this subsection shall constitute a separate offense. A health facility or agency shall not be liable under this subsection unless the health facility or agency, pursuant to a conspiracy, combination, or collusion with a physician or other provider, falsely represents the medical necessity of the particular

> goods or services for which the claim was made.
>
> (3) A person who violates this section is guilty of a felony, punishable by imprisonment for not more than 4 years, or by a fine of not more than $50,000.00, or both." (Emphasis added)

A physician who orders unnecessary laboratory tests from a laboratory may be in violation of Section 7(2) and subjects himself/herself to a 4 year felony and/or $50,000.00 fine. The Legislature believes that medically unnecessary services charged to the Medicaid Program has become such a problem that the above severe penalties are necessary to discourage this activity.

The Attorney General's Medicaid Fraud Unit intends to strictly enforce Section 7 of the Medicaid False Claims Act. Where Attorney General investigators observe billings of laboratory "profiles" on Medicaid patients, the referring physician to the laboratory can be prosecuted.

This letter is not intended to unnecessarily alarm you, but rather to inform you of the above-referenced provision which has been embodied in the Medicaid False Claims Act. This "medical necessity" provision should not change the practice of the vast majority of Medicaid Practitioners. This provision will hopefully affect the practice of that small number of doctors who perform unnecessary services and/or order unnecessary laboratory services.

I invite you to call the Medicaid Fraud Unit to set up a conference, if you wish to discuss the new provision in Section 7 of the Medicaid Fraud Act. The telephone number for the Attorney General Medicaid Fraud Unit is (517) 373-3800 or 373-8455. You may contact Patrick J. O'Brien or Richard Ervin.

Very truly yours,

FRANK J. KELLEY
Attorney General

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PJO:cmr

THE LAWYER DENTIST RELATIONSHIP
PART 1. ON REVIEW OF
MEDICAID DENTAL PROGRAMS
FOR ATTORNEYS

STUDY BY DENTAL SURVEY OF AMERICA
ON MEDICAID DENTAL FRAUD

NORMAN J. CLEMENT DDS.
DARYL E. WILLIAMS DDS. MS.
DALTON P. SANDERS DDS.

INTRODUCTION

Unfortunately for the Dentist, there are very few Attorneyss who have a good understanding of Dentistry, dental terminology, procedure codes and the complexity of dental procedures. This very serious problem could likely be traced to the discernment most people would have in a general population when concerning the field of Dentistry. These authors have found in their practices that a significant majority of patients that we treat are more cognizant of childbearing, hypertension, the common cold than they are about dental decay, periodontal disease; even more importantly what the Dentist does and how the dentist treats these conditions; and lawyers are no differrent. Ask an attorney or a child what a Dentist does and their most likely response is that **they fill and pull teeth.**[1]

It may cost a Dentist around 65,000 to 100,000 dollars, for four year of general dental training at the average Dental School in America; but in order to receive justice the Dentist must spend 50,000 dollars to hire an Attorney in which most of the legal time is being used up teaching Dentistry to the Lawyer. Thus what is happening in several States across America is that the **plea of No Contest** has become the plea that the Dentist cannot afford his/her day in court. Errant, illegal, illogical, medicaid policies are reenforced by the State and Administrative Court Judges; medicaid recipients are then subject to dental practices which are a **IMMINENT** danger to their well being. The Field of Dentistry as well as the Dentists are disgraced by ineffective counsel and unenlightened State Circuit Court Judges having been found **guilty for practicing sound Dentistry.**[2]

Dental Survey of America has compiled and reviewed several State Medicaid Dental Provider Manuals to assess their current appropriateness in providing guidance to the conduct of these State programs and in assuring quality dental care for eligible beneficiaries.

Our studies clearly established what appears to indicate that many States have undermined the integrity and intent of Congress under EPSDT(Early Periodic Screening, Diagnosis and Treatment) Legislation to provide all Comprehensive Dental Care and medically necessary orthodontics by hindering dental health care providers through harassments, indictments, and prosecutions. Therefore, this is a two part series by dentists to familiarize Attorneys with standard dental procedures and terminology to aid them in case preparation for court room presentation.

DISCUSSION

In January of 1988, a group of dentists formed Dental Survey of America and began a comprehensive comparative study of our nation's Medicaid Dental Programs.[3] Copies of 46 State medicaid dental program manuals were obtained. Comparisons were made of the manuals to determine if the respective policies and procedures were consistent with Dental Health Care policies established by the federal government and national organizations.[4]

We found that nearly all State run federally funded Medicaid Dental Programs were in **non compliance** with their own State regulations governing the practice of Dentistry. They were also in **violation** of Federal guidelines as set forth by Congress for the Administering of Medicaid Dental Programs. Almost 96 percent of State run federally funded Medicaid Dental Program Manuals which we reviewed mandated Dental policies and practice standards that were either inconsistent, or incorrect; and some manuals condoned dental procedures that were **non existent** in the current practice of modern Dentistry. In fact these polices and procedures varied so widely from state to state that standard practice of Dentistry as set forth by established Dentistry was **felony fraud** in several States.[5]

THE MUTILATION OF POOR AMERICAN CHILDREN

It is inevitable that some children and adolescents will lose permanent teeth to dental disease or trauma.[6] The removable partial has long been established in dentistry as the single most useful appliance for the management of space and the restoration of masticatory function(false teeth which cover part of the mouth and allows a person to chew). As the result of early loss of permanent teeth in adolescent children, its presence is necessary for the prevention of hypereruption of opposing teeth into the missing space and the collapsing of the entire dental arch (shifting teeth resulting in spaces between the teeth). Policies under the Michigan and Florida medicaid program are written in such a manner that very few (if any) children would qualify for a removable partial denture. In Michigan the policy reads:[7]

> removable partials are only done where there are **(All RECIPIENTS)** "fewer than six teeth are in occlusion in posterior areas." (false teeth which cover part of the mouth are done only when there are less than six top and bottom back teeth touching each other)

in Florida it states:

> " removable partials are only done where there are less than eight posterior teeth in occlusion" (false teeth which cover part of the mouth are only done when there are less than eight top and bottom teeth touching each other)

To the attorney who may have little knowledge about dentistry, these policies would seem to have merit. To a dentist it would be clear that one would literally have to **butcher** a young adolescent child in the dental chair in order to qualify him/her for a removable appliance.

Every dentist knows that there are generally 32 permanent teeth present in the human adult dentition (normal mouth). We also know that there are 12 anterior (front) teeth, and 20 posterior teeth including the third molars(20 back teeth including wisdom teeth.). Using simple arithmetic it should be clear that this policy, if carried out, would be devastating to a young adolescent child's mouth.

For example, a young lady 14 years of age with 16 posterior (back) teeth opposing each other,(eight on top and eight on the bottom touching each other) loses her first permanent molar to dental decay. The dentist in **Michigan** must now remove 10 additional posterior (back) teeth in order to get paid for doing a removable partial denture. Even more ludicrous is the fact that if one or more of the back top or bottom teeth never touched each other, the same child **would not** qualify for a removable partial denture at all. Fortunately, the dentist in **Florida** would be required to remove 8 posterior(back) teeth but would be faced with the same dilemma if one or more back teeth did not oppose (touch) each other.[8]

The Federal District Court of Appeals for the fifth Circuit ruled in Mitchell v Johnston cite as 701 F.2d 337(1983) pg 349, that:

> "the elimination of partial dental appliances on posterior teeth was not based on medical necessity but, rather, on the type of condition to be treated, and was wholly unrelated to the accomplishment of the purpose of EPSDT legislation." As quoted from the courts decision " this finding is also well supported by the record. Expert testimony established a fairly extensive need for the eliminated appliance. Id. at 191-92. Elimination of the appliance could result in periodontal disease, and shifting, misalignment, and possible destruction of front teeth. Indeed, this cutback, couple with the elimination of posterior root canals, removed all of the basic approaches available to a dentist to deal with diseased or missing posterior(back) teeth. TDHR's refusal to cover root canals for posterior teeth meant that seriously damage teeth would have to be removed. **Once removed, however, the posterior teeth could not be replaced with dentures unless the dentist removed more of the child's teeth-including healthy teeth.** This is the type evidence that led the district and the experts to the conclusion that the remaining list of allowable procedures was inadequate to meet the needs served by a restorative dental program. Id. at 192-93.[9]"

This statement alone from the court makes the entire section on partial denture appliances in the States of Michigan and Florida Medicaid

Dental Programs **IN NON-COMPLIANCE ON POINT**. Further in the same court decision the district court ruled, and the Appeals Court affirmed that:

> "when state voluntarily and knowingly accepts terms of federal-state "contract" state is required to fulfill its mandatory obligation under that contract.[10]"

The fact that the States of Michigan and Florida have failed to follow their mandatory obligations by failing to change their policies and procedures for the removable prosthetic appliances makes these two programs an imminent danger to children's health care. Moreover, on July 15, 1988 Kay Johnson of the Children's Defense Fund Washington D.C. wrote:

> "with regards to dental services, each state EPSDT program is required by federal law to provide all dental care, at early an age as necessary, which is needed for the relief of pain and infections, restoration of teeth, and maintenance of dental health(42 CDF Section 441.56(c) (2) 1985). The Health Care Financing Adminstration has broadly interpreted these requirements(Guide to Dental Care. EPSDT-Medicaid, Pub. No. HCFA 24515), and a federal court affirmed the broad intent of this language (Mitchell v Johnston 701 F 2d 337, 5th Cir, 1983).[11] [12]"

The above statement alone also makes these two programs in non-compliance with federal guideline and federal court orders.

WHAT IS TECHNICALLY WRONG WITH MEDICAID DENTAL POLICIES?

Nowhere is **The State of Florida, HRSM 230-22** Dental Provider manual for Childrens Dental Services more flagrantly in error, and fallacious to the policies of modern Dentistry, EPSDT and the will of the Congress to provide health care than in the area of **extraction of asymptomatic impacted teeth**. The following procedural definitions found in the Florida, Michigan, and Ohio's manuals are in clear violation of EPSDT(Early Periodic Screening and Diagnosis and Treatment guidelines. These indicate how medicaid recipients treated under these guidelines are placed in **imminent danger** . This stresses the necessity for Defense attorneys involved in dental medicaid fraud cases to have a thorough working knowledge of dental terminology as well as the practice standards by national organizations, federal guidelines, and the federal courts. To the Dentist these policies would be equivalent to a Physician performing heart by pass surgery using a butter knife.

> From HRSM 230-22 October 15, 1981 Page 4-7, 4-12 Oral Surgery.

(3) The surgical removal of asymptomatic third molars is not compensable. Surgical removal of third molars as a preventive or prophylactic measure is likewise not compensable. **Since full bony impaction are rarely symptomatic**, more attention is given to soft-tissue or partial bony impaction. The removal of third molars for suspected tempero-mandibual joint referred pain is not compensable. All prior authorization requests for the surgical removal of third molars must include a written statement from the dentist stating that symptom of swelling, prevalent infection, or consistent pain is present.

State of Michigan, Rev. 5-20-82, Chapter III pg 32. Medicaid Dental Manual " The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymtomactic teeth or teeth exhibiting no overt pathology is not covered."

State of Ohio, Chapter 35555 pg 12. Medicaid Dental Manual " The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymtomactic teeth or teeth exhibiting no overt pathology is not covered."

Raymond J. Fonseca DMD, Chairman of the Department of Oral and Maxillofacial Surgery University of Michigan states,"the contention that bony impaction are rarely symptomatic is **erroneous**."[13]

The Appeals Court Concluded in **Mitchell v Johnston** that:

8.Non symptomatic Extraction of impacted Teeth.

> The district court also concluded that nonsymptomatic extraction of impacted teeth was a necessary EPSDT service and **we agree**. The testimony at trial clearly indicated that dental conditions do not always manifest themselves in the form of overt symptoms. Thus the district court correctly held that the purposes of the program were frustrated since the treating dentist was required to wait until the condition culminated in overt, painful, costly symptoms before extraction was an allowable procedure. Record, vol 4 at 775. Quite clearly, several severe dental problems could develop without overt symptoms. Record, vol 10 at 199-200. Hence, the elimination of this medically necessary service was improper.[14]

The American Association of Oral and Maxillofacial Surgeons(AAOM) has stated in their Newsletter that:

> "timely removal of impacted and unerupted teeth(e.g., third molars), preferably between the ages of 15 to 25, is a valid and scientifically sound treatment rationale. The overwhelming body of clinical evidence shows that patients with impacted teeth who wait until symptoms appear before having them removed suffer risks of undue discomfort, prolong recovery periods, increase cost of treatment and danger to their general health. **The popular concept that if impacted and unerupted teeth don't bother you, don't bother them, is not supported by the weight of clinical evidence compiled over many years.** The AAOM recommends that the public should consult and oral and Maxillofacial surgeon or dentist before any problems develop. This is preventive dentistry. Waiting for impacted and unerupted teeth to cause pain or more serious problems will only result in unnecessary complications and additional cost for treatment."

Any one who was in procession of a pencil and a piece of paper could have written the **American Association of Oral and Maxillofacial Surgeons** at 211 E. Chicago Ave, Chicago IL 60611 or call at 312-642-6446 and gotten the newsletter on Impacted and Unerupted Teeth for **free.**

ORAL SURGERY; MAY BE HAZARDOUS

Similarities in the same procedure definitions being incorrectly defined in the States of Florida, Massachusetts, and Maine Medicaid Dental Provider Manuals were especially troublesome in the areas of Oral and Maxillofacial Surgery. The extraction of a **single tooth** which was incorrectly defined as a **simple extraction** by the closed method or "forceps only technique" and surgical removal of an erupted tooth was the removal of **any erupted tooth** by the "open method" [both definitions which are not found anywhere in modern dentistry]. The Dental Survey of America team also uncovered where there was conspicuous errors of definitions or dental policy and procedures in Florida's Medicaid Dental Providers Manual it seemingly had been corrected in the Massachusetts and Maine Medicaid Dental Provider Manuals, example:

Florida Medicaid Dental Handbook HRSM 230-22 October 15, 1981 section 4-12 Oral Surgery page 4-7.

> **Simple extraction** is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extractions can be performed as necessary. HRS will investigate an unusual number of simple extractions in the **primary dentition** to ensure that a significant health service has been performed.

Commonwealth of Massachusetts Medical Assistance Program Provider Manual Series Dental Manual 11/29/79 page 4-15.

> **Simple extraction** the removal of a permanent or deciduous tooth by the closed method of "forceps only" technique in which a flap is not retracted. All simple extractions may be performed as necessary. The Department may investigate an unusually heavy use of extractions in the **primary dentition** to ensure that a significant health service has been provided.

Above, the words primary dentition(s) from the Florida and Massachusetts Dental provider manuals have been underlined. Note the grammatical errors and note the use of the term **"forceps Only ."** Now notice below the subtle changes in the Maine Dental provider manuals as the reference to the primary dentition has been eliminated.

Maine Medical Assistance Manual Dental Services 9/1/86, page 9.
25.03-7 Oral Surgery (Codes D7000-D7999)
A. Exodontic Services
1. Simple Extraction

> **Simple extraction** the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extraction may be performed as necessary. The Department may investigate an unusually heavy use of **extractions** to ensure that a significant health service has been provided.

Any tooth, no matter how easy the extraction may appear has the potential for complications. The use of the term **simple extraction** is both inconsistent and incorrect with the current practice of dentistry. The term is **single extraction** American Dental Association (ADA) billing procedure code 07110, which all 3 manuals use with exception of Florida where the term is described as the extraction of the **first tooth in quadrant**. In Florida, both the procedure definition and the procedure code are incorrectly defined. Massachusetts and Maine both use the term simple extraction incorrectly as their procedure definition but correctly use the term **single extraction** in their ADA billing procedure code 07110.

In both the Florida, Maine and Massachusetts Medicaid Dental Provider Manuals the definitions for the Surgical extractions were found to be so flagrantly incorrect to the point that each State's Dental Program Manuals has committed either the exact, identical technical or grammatical errors Example, the Florida Program **(extract or section of a tooth)** of which only the grammatical error had been corrected in the Maine and Massachusetts. Medicaid Dental Providers Manual**(extraction or the sectioning of a tooth)**.

Florida HRSM 230-22, Page 4-7, October 15, 1981

> Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to **extract or section of a tooth.**

Commonwealth of Massachusetts Dental Manual Page 4-20, November 29, 1979.

> Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of substantial amounts alveolar bone in order **to extraction or the sectioning of a tooth.**

Maine Medical Assistance Manual, Dental Services Page 9, September 1, 1986.

> Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of substantial amounts of alveolar bone in order to effect the **extraction or the sectioning of a tooth.**

The Massachusetts and Maine Medicaid Dental Program Manuals are so bad that they both go on to reference the open method technique on all of the extractions for impacted and unerupted teeth. The Open Method of extraction is a procedure method of extraction which is not known in Dentistry or to the training of the modern dentist. R.J. Fonseca DMD, Chairman Department of Oral Maxillofacial Surgery University of Michigan states:

> "the reference of differentiating between open and closed extraction is too simplistic and does not reflect real clinical practice."[15]

Once again the Oral and Maxillofacial Surgery Procedural Terminology manual of the American Association of Oral and Maxillofacial Surgeons descriptions for the extraction of teeth is readily available to anyone who can obtain them for free by writing 211 E. Chicago Ave. Chicago IL. 60611 or calling (312) 642 6446.

ORAL SURGERY:
ALVEOLOPLASTY AND THE RESHAPING OF JUSTICE

The most frequently performed procedure in pre- prosthetic surgery is Alveoplasty[16] an any surgery performed on the alveolar process can be considered pre-prosthetic surgery.[17]It is well known that the Criminal Justice System does mis-represents the rights of poor people who otherwise cannot afford legal representation. Yet, surprisingly the same can be said about the Dentist accused of Medicaid Fraud in which lawyers have no understanding about the field of Dentistry. This section Alveoplasty and The Reshaping of Justice shows the inherent weakness of a Administrative Hearing Officer, and State Court Judge who found a Dentist guilty for doing Dentistry. In their decisions Leon County Judge Charles McClure and Administrative Hearing Officer William R. Cave over turned every piece of scientific dental research including Journals and Textbook publication used in the field of Dentistry. The following is a summary on how illogical Medicaid policies nearly cost one Dentist his freedom and how the same policies are a **IMMINENT DANGER** to the public.

From: HRSM 230-22 p.p. A1-5-5,**(FLORIDA)** the procedure Alveoplasty is listed by dental procedure code 07310 and 07320 as Alveolectomy which is incorrect.(see ADA procedure codes)

> **October 15, 1981, HRSM 230-22,** Childrens Dental Service Florida Medicaid.

Alveoloplasty

07310 Alveolectomy, per quadrant, in conjunction with extractions.

07320 Alveolectomy, per quadrant, not in conjunction with extractions.

07350 Stomatoplasty

From: Oral Surgery , a textbook edited by James R. Hayward, Chapter 10, by James R. Hooley and Emil W. Steinhauser p.p. 137.

> "Any surgery performed on the alveolar process can be considered pre-prosthetic surgery. The subject matter in this chapter is concerned with those surgical procedures which are most intimately related to the ultimate wearing of dental prosthetic appliance." A Dental prosthetic appliance would include a Complete Denture(Top and bottom false teeth) a partial denture(partial false teeth)or a fixed bridge.

From: Testimony of Morine Funderburk, Glen Stone, Irving Fleet DDS., administrative hearing Florida case 86-3023, Florida Department of Health and Human Services (HRS) v Dr. C.

> 15. It was determined that Dr. C. filed an excessive number claims for alveolectomies. Dr. C. received payment for 117 alveolectomies performed on 52 children.

From: Oral Surgery textbook p.p 137.

> "The principles of pre-prosthetic surgery frequently are ignored. Dentures are inserted on residual alveolar ridges that are too sharp, that have bony undercuts, or have inadequate vestibular heights or depths. Successful prosthodontics therapy depends on successful and carefully planned pre-prosthetic surgery."

From: Hearing case 86-3023 **Florida Department of Health and Human Services** (HRS) v **DR. C.** and HRSM 230-22.

> **HRSM 230-22 at paragraph 4-12 i states.** "Alveolectomies are indicated only on extreme cases without which insertion of dentures or partial would be impossible." **

From: Oral Surgery textbook, p.p. 145.

> "The **most frequently performed procedure** in pre prosthetic surgery is the **alveoplasty**. Of all of the procedures in minor oral surgery perhaps none is as demanding. As with any surgery, the results cannot be evaluated until healing has taken place. It is surprising to see the wide variation of results which would seem to indicate that performing a satisfactory alveoplasty is a good indication of one's surgical skill."

From: Florida Department of Health and Human Services (HRS) v DR. C. case no. 86-3023.

> It is standard dental practice to perform **alveolectomies(a reshaping of the bone)** only where a denture is supplied.

From: Oral Surgery textbook p.p. 145

> "Until the last decade, the procedure most commonly performed was referred to as **alveolectomy.** Interpreted literally, this term means the surgical removal of part or all of the alveolar process. The term **ALVEOPLASTY** is used since it better describes the minimal reshaping of the alveolar process."
>
> "**Alveoplasty** includes the excision of bony projections and undercuts followed by minimal recontouring of the alveolar process. It is performed to facilitate removal of teeth, to correct irregularities of the residual alveolar ridge following removal of one or more teeth, and to prepare the residual ridge for the reception of dentures. The principle goals of alveoplasty are the proper contouring of the alveolar process and the preservation of as much alveolar bone as possible."**

From: Florida HRS v. Dr. C. case no. 86-3023.

> Performing an **alveolectomy** on a child is not a common practice and there was no indication that Dr. C performed the procedure in preparation of insertion of partial or dentures as required by **HRSM 230-22**.

**(note below that alveoloplasty in Illinois is felony fraud in Florida)

From: Illinois Medical Assistance Program. Section II, Chapter D-200, Dental Services.
D-210 COVERED SERVICES, February 1987, II-D-8

D-217.2 Alveoloplasty

> **Alveoloplasty** is a covered service only for children. Prior approval is required for alveoloplasty as a separate procedure. Study models are to be submitted with the prior approval request.**

From: October 6, 1987, Before the Honorable Charles D. McClure, Circuit Judge SECOND JUDICIAL CIRCUIT IN AND FOR LEON COUNTY, FLORIDA case no. 86-3023.

THE COURT:

> On 97 occasions you filed claims for extracting more than one first tooth, which was apparently against procedure. On 117 occasions you received payment for reshaping of the bone--cannot pronounce the word here-performed on 252 children, which in the finding of the administrative officer was excessive.**

> **(note below that alveoloplasty in Illinois is felony fraud in Florida)

From: Oral Surgery textbook p.p. 148.

"**Labial and Buccal Cortical Alveoplasty:** This the most common form of alveoplasty, performed to a certain degrees following almost all multiple extractions. It is simply reshaping the alveolar process by removing labial and buccal undercuts and all sharp and rough bony projections."

FROM
DENTAL SURVEY OF AMERICA
BY
NORMAN J. CLEMENT DDS,
DARYL E. WILLIAMS DDS., MS.
DALTON P. SANDERS DDS.
(313) 861 3209 or **(313) 342 7901**

June 5, 1989

DEPARTMENT OF HEALTH AND HUMAN SERVICES STUDY CONFIRMS FINDINGS OF DENTAL SURVEY OF AMERICA

A report highly critical of Dental health policies in America was issued May 16th to the Congress. The report called Improving the Oral health of the American People Opportunity for Action, states," Improved oral health for all Americans has been constrained, in large part, by the low priority and visibility afforded oral health activities at the Federal Level." The Study found Departmental dental activities to be fragmented, lacking and uncoordinated, preventing DHHS from effectively carrying out its responsibilities. Most importantly, studies says "it was unable to identify within the Department either a discernible oral health policy, or mechanism whereby oral health perspectives are assured of receiving appropriate consideration in the development of health policies."

Daryl Williams and Norman J. Clement both with Dental Survey of America feels this study collaborates all of our findings. DSA who also gave testimony in this study has been highly vocal of policies found in the State run Federally funded medicaid dental programs throughout the country. In one publication called Why Poor Johnny doesn't Smile DSA wrote medicaid policies are primitive, abysmal, and nonexistent.

The study can be obtain from Dr. Daniel F. Whiteside, DDS Assistant Surgeon General and Chief Dental Officer, United States Department of Public Health, Rockville Maryland 20857, 301/4436395.

Dental Survey of America(DSA) was founded in January 1988 by a group of dentists who are graduates of the University of Michigan School of Dentistry. The goals, of DSA are to conduct research and promote forums on Dental Public Health Policy. Dental Survey of America has published four articles in less than one year concerning these morally appalling standards found in our nations medicaid dental program manuals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
Office of the Surgeon General
Rockville MD 20857

Norman J. Clement D.D.S.
Chairman, Dental Survey of America
P.O. Box 13328
Tallahassee, Florida 32317-3328

Dear Dr. Clement:

Thank you for your assistance in the preparation of the Report to Congress on Dental Activities of the Department of Health and Human Services (DHHS). Your comments were very helpful in identifying issues to be addressed in this document.

The Interim Study Group on Dental Activities, chaired by Dr. Lawrence Meskin, submitted to me its report in April, which I subsequently forwarded to the Department. The report was approved and transmitted to the Congress on May 16, and now is available for public distribution. I am enclosing a copy of the final document, Improving the Oral Health of the American People: Opportunity for Action, along with my transmittal report to the House of Representatives, for your information and use. The same report also was transmitted to the Senate. Please feel free to copy and distribute the report as necessary.

Sincerely yours,

Daniel F. Whiteside

Daniel F. Whiteside, D.D.S.
Assistant Surgeon General
Chief Dental Officer, PHS

Enclosure

Daniel F. Whiteside, D.D.S.
Chief Dental Officer, PHS
Parklawn Building, Room 9-03
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Whiteside:

The members of the Interim Study Group on Dental Activities are pleased to respond to your request to examine the oral health activities of the Department of Health and Human Services, and to make recommendations regarding organizational and administrative methods for achieving maximum coordination and effectiveness of those activities. Our enclosed final report is representative of our broad consultation with all interested members of the oral health community.

As stated in our report, we believe that the Congressional request for this study has come at an opportune time. The profession of dentistry has undergone substantial change in the last few decades, and research advances have made possible significant improvements in the oral health of many Americans. However, even more dramatic progress is possible. We believe that a well-coordinated dental presence within the Department, working closely with all other sectors of the oral health community, is a critical necessity for the achievement of this potential.

It is our hope and belief that the implementation of the recommendations included in this report will serve to establish an organizational structure which will enhance Departmental involvement in oral health activities. We are honored to have had this opportunity to provide our scientific and administrative advice to the Department of Health and Human Services.

Sincerely,

Lawrence Meskin

Lawrence H. Meskin, D.D.S., Ph.D.
Chairman
Interim Study Group on
Dental Activities

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IMPROVING THE ORAL HEALTH OF THE AMERICAN PEOPLE

OPPORTUNITY FOR ACTION

A STUDY OF THE ORAL HEALTH ACTIVITIES
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MARCH 1989

THE CHARGE

In response to directives from the Committees on Appropriations of the House of Representatives and the Senate to "address the identification of appropriate goals and priorities in oral health," and to "consider appropriate organizational and administrative arrangements for achieving maximum coordination and effectiveness of dental health activities" within the Department of Health and Human Services (DHHS), an Interim Study Group on Dental Activities was formed. (House Report No. 100-256, pages 98-99, and Senate Report No. 100-189, pages 188-189).

The Study Group was composed of individuals from the public and private sectors with broad backgrounds in oral health, representing academia, research, management, and the delivery of services. The Study Group received oral and written testimony from individuals and major national oral health organizations (Appendices A and B). Additional resources included Federal and non-Federal documents developed in previous years and an inventory of current DHHS oral health activities especially prepared for this study (Appendices C and D).

A PROFESSION IN TRANSITION

In the first half of this Century, nearly all Americans were affected by tooth decay and its painful and costly consequences. The primary focus of dentists was on the repair of cavities or the extraction of teeth that could not be saved. A lack of understanding of the cause of decay and the disease process contributed to this concentration on restoration and repair, and the resulting reconstructive approach to dentistry.

The birth of modern biomedical science after World War II revolutionized understanding in all the health disciplines. Past beliefs and idle speculations in dentistry gave way to the knowledge that decay--dental caries--is an infectious disease. Epidemiological studies and laboratory research also established the value of fluoride in preventing decay. The early application of this new knowledge brought about immediate results in the form of declines in caries prevalence in school children. By the 1950's and 1960's, research had established that the periodontal diseases were also infectious diseases associated with bacteria in dental plaque, and like caries, could be prevented. These revelations about the two most prevalent, indeed endemic, dental diseases have caused a fundamental shift in the focus of dentistry from the repair and replacement of teeth to the prevention of disease and the preservation of the natural dentition for a lifetime. Indeed, leaders in the dental community now talk of the prospect of essentially eliminating caries and periodontal disease in the early decades of the 21st century.

This change in perspective is accompanied by awareness that advances in dentistry have been occurring on other fronts as well. Researchers are exploring the causes of developmental defects such as cleft lip and palate. Pain research is benefiting from discoveries about the body's own pain-controlling systems. Microbiologists and immunologists study oral pathogens and use genetic engineering methods to develop experimental vaccines for herpes. Widespread adoption of cell and molecular biology techniques have revealed a world of growth factors, neurotransmitters, and other molecules vital to growth, repair, and regeneration. These developments have been accelerated by the AIDS epidemic and the realization that oral complications of HIV infection are common and often occur early in the course of infection. The profession also is increasing emphasis on older Americans and individuals of any age who may be at high risk for oral health problems.

UNFINISHED BUSINESS

With all these advances in knowledge and technology, there remains a need to bring the benefits of dental disease prevention and improved treatment to all segments of the population. A major challenge is to increase awareness and access to services by special populations, such as the disadvantaged, the underserved, and the institutionalized. These populations generally rely upon the public sector for oral health care services and/or financing, and often gain access to health care only after an acute dental condition has developed. Moreover, if dentistry is truly to move on with its agenda of eliminating caries and periodontal disease in future generations, prevention efforts must be based on a combination of strategies. For caries, this means using fluorides--which work best on the smooth surfaces of teeth--and dental sealants, plastic films which prevent decay on the chewing surfaces of teeth. However, recent evidence suggests that dental sealants have seen very limited use. It will be important to increase awareness by the public of the value of this proven safe and effective measure.

Indeed, the public has shown increasing willingness to be a partner in prevention efforts by adopting appropriate oral self-care and better eating habits, and by seeking dentists for check-ups. Dentists, too, have added to their preventive armamentarium with new antimicrobials and antibiotics for the chemical control of plaque in periodontal diseases.

NEW ORAL HEALTH DATA

Results of these multiple strategies for prevention can be seen in the changing statistics on dental disease. A recent epidemiological survey of American schoolchildren aged 5-17 (NIDR, 1986-87) showed that tooth decay had decreased by 36 percent from levels reported in a 1979-80 study. Fifty percent of the children surveyed had no dental decay in their permanent teeth, compared with 37 percent in 1980, and an estimated 28 percent in the early 1970's. In adults, recent surveys have shown that edentulism (loss of all teeth) in adults has decreased from levels reported a generation ago. Significantly, these declines in caries and tooth loss have led to savings in the Nation's dental bill of an estimated $2 to $3 billion a year.

Nevertheless, there is still far to go:

- In children, decay increases with age. 84 percent of all 17-year olds surveyed had experienced tooth decay in their permanent teeth, and the average 17-year old examined had 8 decayed or filled tooth surfaces.
- The tooth surfaces most commonly affected by decay are the chewing surfaces of the posterior teeth - those that could be protected by dental sealants.

Furthermore, adult oral health fails to demonstrate a decline in decay prevalence similar to the one seen in children. The most recent adult survey (NIDR, 1985-86) provides data on employed adults and older Americans well enough to be seen at senior citizen centers (and this may underestimate the magnitude of the problems):

- Nearly 80 percent of all Americans have some form of periodontal disease, and both prevalence and severity of these diseases increases with age.
- The average employed adult has 23 decayed or filled tooth surfaces.
- Only a little more than a third of employed adults have retained at least 28 permanent teeth.
- 41 percent of older Americans have lost all of their teeth.
- The average older American has lost 18 teeth.

How do these data translate to everyday life? Untreated decay, gingivitis, and more advanced periodontal diseases can be painful, interfere with chewing ability and speech, alter the choice and taste of foods, and affect general health. Edentulism and malocclusion also can interfere with normal oral functions. More importantly, the lowered self-esteem that so often accompanies these conditions can lead to social withdrawal, as well as lowered expectations and opportunities for education and employment.

Other oral diseases present a greater threat to systemic health. Most notably, approximately 30,000 persons develop cancers in the oral cavity or pharynx each year, and 9,400 people die. Nor can one afford to overlook the relation between oral and general health. No person can be considered healthy when active disease persists in any part of the body. In addition, some systemic diseases, such as diabetes, rheumatoid arthritis, and heart valve disease, have effects on, and are affected by, the oral tissues or their treatment.

THE FINANCIAL BURDEN

Last year, oral disease ranked second in total direct costs of the Nation's thirteen leading health problems.

- Americans spent an estimated $27.1 billion on oral health care in 1988.
- Oral health spending accounted for 6.5 percent of the total health care bill for the Nation.
- Of the total amount spent for dentists' services, 61 percent was paid directly by the consumer, 37 percent was covered by private insurance, and 2 percent was paid by Federal and State Governments, the majority through Medicaid.
- The total oral health bill represents a per capita expenditure of $130.

The financial implications of oral disease are not limited to direct costs for services and products. According to the 1986 National Health Interview Survey (NCHS, 1986), dental-related illness resulted in 6.4 million days of bed disability, 14.3 million days of restricted activity, and 20.9 million days of work loss, of which 16 million days were for oral health care and treatment.

UNMET NEEDS AND SPECIAL POPULATIONS

Closer examination of the data underscores the fact that improvements in oral health have not been realized equally throughout the population. Over half of the U. S. population lacks oral health insurance. Only a fraction of the Medicaid-eligible individuals receive oral health care. These individuals not only have the least opportunity for access to oral health services, but it can be presumed that they also have the greatest need.

In addition to problems of access, some individuals, for one reason or another, are at greater risk for disease. Analysis of the data on tooth decay in schoolchildren reveals that 60 to 75 percent of the disease is concentrated within 20 percent of the population. Further epidemiological and biomedical research is needed to define more precisely the factors that predict which individuals are more susceptible to disease. More intensive preventive efforts must be directed at those identified as high risk.

Another important issue is the fact that the provision of oral health care for special populations such as the handicapped, the medically compromised (including AIDS patients), and institutionalized patients is woefully inadequate. The oral health needs of these populations must be addressed not only for tooth decay, but also for the entire spectrum of oral diseases and disorders, seen in relation to their overall health problems and medications used. The "graying of America" demands evaluation of the availability of services for the growing numbers of older Americans. Immigrant and minority populations and the large number of underinsured Americans also must be considered.

In summary, the data show that substantial needs remain. Not only are mainstream Americans failing to realize all the benefits of preventive measures, but many others are effectively outside the health care system. The Study Group believes that conditions of less-than-optimal oral health should not be acceptable to the American people, nor to the dental profession. The knowledge and technology to facilitate dramatic improvement in oral health for all individuals is here now, but we are failing in providing universal access to this basic technology.

THE FEDERAL ROLE

The mission of the Department of Health and Human Services (DHHS) is "to promote and assure the highest level of health attainable for every individual in America." In terms of oral health, there is much to be done to achieve what is needed and what can be accomplished at minimum cost. A national focus for coordinating public and private activities to improve oral health is essential. The mission of DHHS is consistent with this function. To carry out its responsibilities effectively, DHHS must assess oral health status, set objectives, and coordinate public and private sector efforts. One fundamental responsibility of government is the conduct and support of research, including the fields of biomedical, clinical, educational, health services, and demonstration research. The government also has responsibility in meeting the needs of underserved groups, including ensuring funding for the delivery of oral health care. To maximize performance, the DHHS should have access to the best advice from all sectors of the oral health community. In addition, effective means of accountability to the public, through elected officials, should be in place.

The Study Group is concerned that the Department presently is not prepared organizationally to address the full range of its responsibilities with respect to oral health. As is clearly indicated in the document, An Inventory of Resources and Activities Devoted to Dental and Oral Health in the Department of Health and Human Services (Executive Summary, Appendix D), with the exception of financing, the oral health responsibilities of the DHHS are carried out by the Public Health Service (PHS). The Study Group believes that neither the PHS nor its agencies can effectively act alone, but should work closely with all components of the oral health care community to the extent that this community affects the health of the public.

The oral health care community traditionally is divided into three components: service, research, and education. Overwhelmingly, oral health services to individuals are delivered by the 85 percent of the Nation's dentists who are in private practice. Community prevention efforts and health care activities targeting underserved or special populations have been carried out largely by public programs. Major research is conducted in university settings, typically funded by the PHS through the National Institute of Dental Research (NIDR). Curricula design, professional training, and the forecast of skills needed in the future are primarily the responsibilities of the dental and dental auxiliary educational institutions. Effective coordination among all of these sectors is vital to the goal of achieving optimum oral health for our population, at the least cost. Presently, this coordination is non-existent, and, as a result, oral health improvement efforts lack central focus, direction, and impact.

AGENDA SETTING

A primary obligation of the PHS is to provide perspective and direction to health activities by setting health agendas for the Nation. For a government which emphasizes decentralization, the importance of nationally identified goals lies in focusing, motivating, and encouraging the commitment of public and private resources at all levels. The Study Group identified notable examples that demonstrate the capacity of the PHS to carry out this function, while at the same time pointing out conditions which impede effective action.

Since 1980, the Nation's oral health care community has been working toward oral health goals set forth in the 1990 Health Objectives for the Nation. The Centers for Disease Control (CDC) has had the lead responsibility for the development of these objectives and the monitoring of progress. Revised goals for the year 2000 now are being formulated. While the initial concept for these objectives was provided by the PHS, their actual development is the product of a widely representative workgroup, using information and testimony gathered from extensive public hearings. The goals identified will serve as the focus for oral health improvement efforts among all components of the oral health care community. Success in meeting these national goals depends on the ability of the various programs to work together throughout the coming decade.

A second example of agenda-setting within the PHS may be found in an important oral health initiative for adults and older Americans. In 1987, in House Report No. 100-689, the Committee on Appropriations requested that the NIDR develop a national program of oral health promotion for adults, with emphasis on older adults. Experts from within and outside the Federal Government were convened to consider the feasibility of a national adult oral health program. In 1988, the Congress requested that the NIDR prepare a report on the progress of this initiative. The resulting report, "A Research and Action Program for Improving the Oral Health of Adults and Older Americans," outlines goals and objectives for this population. The initiative is envisioned as a multi-agency, public/private effort addressing research, education, and services delivery.

A similar initiative, designed to benefit the oral health of mothers and children, is in the early stages of development. Under the leadership of the Bureau of Maternal and Child Health and Resources Development, of the Health Resources and Services Administration (HRSA), a consultants' group has been assembled to identify relevant oral health issues and problems with the intention of developing an oral health promotion agenda for American mothers and children. As is the case with the adult oral health initiative, this broad agenda will bring together all sectors of the oral health community. Coordination of efforts, based on clearly enunciated goals and appropriately shared responsibilities, will be the key to success.

In the course of developing these initiatives, the PHS has sought the advice of knowledgeable non-Federal experts and organizations. Similarly, the PHS cannot act alone in the implementation of the programs. In order to have a lasting impact, these health promotion programs must be carried out as broadly based health initiatives, involving a broad spectrum of Federal and non-Federal agencies and activities. Success depends on full participation by the various sectors of the oral health community, including:

- the oral health education system - to stimulate a more preventive orientation within the profession,
- the oral health research community - to expand and disseminate knowledge and monitor changes in disease patterns,
- state and local health departments - to implement community oral disease prevention measures,
- private dentistry - to provide treatment and prevention services on an individual patient basis,
- organized dentistry - to direct patients to care and to improve access,
- public health dentistry - to identify and target high risk and underserved population groups, and
- Federal programs - to deliver services to designated Federal beneficiaries (e.g., migrants, Native Americans, inmates of Federal prisons, veterans).

Other activities would be required from these and still other components. Ideally, the PHS should serve as the focus for the coordination of the various components in the public's interest. This would require that the relevant PHS agencies work closely with one another at each stage in the implementation of new initiatives. For lasting results, an oversight and advisory structure should be established to monitor activities and make appropriate revisions in plans, as well as encourage fruitful collaborations in pursuit of the goals.

The PHS can best create the required constructive atmosphere by providing implementation strategies and consultation services, and acting in the role of coordinator and clearing house. A key component in this role is the maintenance of open lines of communication between the Federal and non-Federal sectors of oral health care, and, just as importantly, among the various PHS agencies which work with outside agencies. In accord with its mission, the PHS also should establish a leadership role in matters concerning the oral health of the nation, including policy development, oral health evaluation and monitoring, oral health manpower, biomedical and oral health services research, quality assurance, access to care, health care economics, and education. Evidence presented to the Study Group suggests that certain structural changes within the PHS would enhance the Service's ability to assume this broad role.

As a preliminary and critical component to the Study Group's task, an inventory of current DHHS oral health activities was completed during the Fall of 1988. This survey reveals that the oral health activities of the Department, and the resources devoted to those activities, have been disaggregated, dispersed, reduced drastically, or altogether eliminated since 1972. In FY 1988, DHHS expenditures for oral health activities (excluding Medicaid) totaled over $210 million. Approximately 62 percent, or $134.8 million, was devoted to research activities--a figure which represents little change in constant dollars since 1972. Only 28 percent, or $60.8 million, was allocated for direct services. Support activities, such as technical assistance, consultation, and standard setting--activities which could greatly enhance the Department's ability to fulfill its coordinating role--accounted for only 2 percent of the expenditures.

The Inventory also shows that the emphasis on decentralization in recent years has resulted in severe fragmentation of the remaining oral health programs, decreased interagency communication, and limited opportunities for collaboration among the various Departmental programs, despite the fact that they share the goal of improving the oral health of the Nation. Decreased collaboration leads to duplication of efforts in some areas and absence of efforts in other areas, and results in uncoordinated oral health programs which lack direction or purpose. The attainment of a unified program is hindered primarily by the lack of a clear focus for the Department's oral health activities. No single entity has been empowered and enabled to coordinate oral health activities.

Moreover, the Inventory states that "...it is now difficult to find any central unit which can lay claim to Dental Policy as its mission. Both the Chief Dental Officer and the Deputy Chief Dental Officer occupy full time positions of importance, as the Director, Bureau of Maternal and Child Health and Resources Development, and the Deputy Director of NIDR, respectively. Thus, their ability to provide the policy focus is constrained by other duties." The Study Group was unable to identify within the Department either a discernible oral health policy, or a mechanism whereby oral health perspectives are assured of receiving appropriate consideration in the development of health policies.

This lack of a distinct focal point also has decreased communication between the Federal and non-Federal sectors of the oral health care community. Many state and local programs and other oral health organizations submitted testimony to the Study Group decrying the lack of a visible contact point for obtaining consultation or technical assistance from the Department in matters related to dentistry. Furthermore, the Inventory revealed that some agencies which report oral health activities have little or no oral health expertise within the agency.

Other information obtained from the Inventory indicates that the communication lines essential to a constructive atmosphere and the effective coordination of national initiatives are not apparent. In the present environment, the PHS has little hope of fulfilling its leadership role in the development and maintenance of timely national oral health policies, goals, and implementation strategies.

Testimony submitted to the Study Group by the Nation's major oral health organizations support these concerns and demonstrate that the oral health care community is very much interested in the role of the Public Health Service in efforts to improve the oral health of the Nation. Much of this testimony concentrated on the organizational structure of the PHS and the interaction between the PHS and the other sectors of the oral health care community.

RECOMMENDATIONS

The Interim Study Group for Dental Activities evaluated the organizational structure of the oral health activities of the Department of Health and Human Services and submits three recommendations to improve the effectiveness of these activities.

Recommendation 1: Establish a focus for oral health activities in the Department of Health and Human Services with clearly visible administrative and policy responsibility.

The individual charged with this responsibility should serve as the center for the coordination and delegation of all oral health activities within DHHS. Since the majority of health activities of the DHHS are carried out at the PHS level, this central focus most appropriately would be located within the PHS at the level of the Office of the Assistant Secretary for Health. The ability of this individual to monitor oral health issues within the Department would enable the PHS to assume a leadership role within the oral health care community. The position would serve as the visible contact point within the Department for individuals and organizations outside the DHHS seeking information or consultation. The individual also would serve as the principal oral health advisor to the Secretary of HHS. Ideally, the position calls for an individual whose full time would be devoted to oral health issues, and whose activities would be supported by an appropriately staffed and financed office.

While direct line operational authority is not recommended, this individual must have ready access to oral health program personnel in the various DHHS agencies. This person must be able to track progress of programs, and maintain constant awareness of all oral health issues and activities within the DHHS. Likewise, the DHHS oral health program personnel must have equal access to this office.

The person coordinating oral health activities for the DHHS should be required to appear before the Congress on a periodic basis, but at least once a year, to report on the oral health status of the American people, and to summarize DHHS oral health activities and progress toward Departmental goals on improving oral health.

Recommendation 2: The individual serving as the focus for oral health activities in the DHHS should be advised by a formally chartered Committee.

The Advisory Committee should be composed of representatives from the dental research, education, and service sectors drawn from outside the Federal Government; representatives from national private and public health organizations; representatives from the lay public; and at least one ex officio representative from the Department of Defense and one ex officio representative from the Department of Veterans Affairs. The Advisory Committee should meet no fewer than three times annually to review and advise on past and future activities. Regular meetings also would assure the maintenance of an open dialogue among all sectors of the oral health care community.

The Advisory Committee should be required to develop and submit to the Congress a biennial report on oral health accomplishments, opportunities, and needs.

Recommendation 3: Establish a strong, clearly identified, oral health presence in any DHHS agency which regularly conducts oral health activities.

The American people deserve the benefit of professional expertise in any program which affects their oral health, whether in the area of prevention, direct care delivery, research, or financing. Any DHHS agency not regularly involved in oral health care should establish a systematic procedure for obtaining oral health consultation services whenever an activity involves oral health issues.

These recommendations should be established by law, and the Secretary, DHHS, should be charged by the Congress to develop and implement an organizational arrangement that will support these activities.

Adoption of these recommendations would not require a substantial infusion of new resources. Their implementation will ensure the essential integration of oral health activities and the inclusion of an oral health perspective in the Department's health policies. The Interim Study Group on Dental Activities believes firmly that taking these steps will lead to an enhanced DHHS involvement in oral health activities--a necessity if the oral health community is to realize its full potential in improving the health of the American people.

APPENDIX A

INDIVIDUALS AND ORGANIZATIONS SUBMITTING TESTIMONY

Alabama Department of Public Health

American Academy of Oral Medicine

American Academy of Pediatric Dentistry

American Association for Dental Research

American Association of Dental Examiners

American Association of Dental Schools

American Association of Public Health Dentistry

American Board of Dental Public Health
American Dental Assistants Association
American Dental Association
American Dental Hygienists Association
American Oral Health Institute
American Public Health Association
Arizona Department of Health Services
Association of State and Territorial Dental Directors
Dental Survey of America
Federation of Special Care Organizations in Dentistry
Georgetown University School of Dentistry
Georgia Department of Human Resources
Illinois Department of Public Health
Meharry Medical College School of Dentistry
The University of Michigan School of Public Health
National Dental Association
Nebraska Department of Health
Ohio Department of Health
The University of Texas Health Science Center at San Antonio
Wisconsin Department of Health and Social Services
World Health Organization, Oral Health Unit

Robert Mecklenburg, D.D.S., M.P.H.
Former Chief Dental Officer, PHS
RADM, Public Health Service (Retired)

John D. Suomi, D.D.S., M.P.H.
CAPT, Public Health Service (Retired)

APPENDIX B

ISSUES IDENTIFIED IN TESTIMONY

ORGANIZATIONAL

- strengthened central focus/Chief Dental Officer (CDO)
- better coordination among agencies
- dental presence in all agencies
- Federal government assume leadership role
- strengthen regional offices
- qualifications of CDO - Public Health background
- agencies identify goals
- improved minority opportunities in PHS

COMMUNICATION

- communication/consultation/input from States
- clear contact point
- interaction with national dental organizations
- improved communication between Federal and non-Federal programs
- receive input from private dentistry

RESEARCH
- transfer of research findings
- increase health services research
- NIDR maintain separate research mission
- greater involvement of minority researchers

SERVICES
- prevention orientation
- increase access for underserved and special populations

FUNDING
- promote dental direction in MCH Preventive Block Grants
- increase funding for dental programs

OTHER
- review and monitoring of State Medicaid practices
- licensure for dental assistants
- effective use of dental hygienists
- publish nationwide list of State Practice Act violators

APPENDIX C

RESOURCE DOCUMENTS CONSIDERED BY THE STUDY GROUP

Ad Hoc Task Force on PHS Dental Activities. Report to the Chief Dental Officer, PHS. July 15, 1980.

Bureau of Health Professions, Health Resources and Services Administration, DHHS. Sixth Report to The President and Congress on the Status of Health Personnel in the United States. June, 1988. Chapter 5: "Dentistry"

Corbin SB, Kleinman DV, Maas WR, and Schneider DA. Promoting Health/Preventing Disease. Report of the Mid-Course Review of the Fluoridation and Dental Health 1990 Objectives for the Nation. Richmond, Virginia: American Association of Public Health Dentistry, 1985.

Dental Affairs Staff, Office of the Assistant Secretary for Health, Department of Health Education and Welfare. Dental Program Inventory. November, 1975.

Dental Affairs Staff, Office of the Assistant Secretary for Health, Department of Health Education and Welfare. DHEW Dental Activities. January, 1979

Dental Affairs Staff, Office of the Assistant Secretary for Health, Department of Health Education and Welfare. Dental Health Activities in Community Health Programs Administered by the PHS Health Services Administration: A Review Through FY 1981. October, 1981.

Epidemiology and Oral Disease Prevention Branch, National Institute of Dental Research, National Institutes of Health, DHHS. Oral Health of United States Adults. The National Survey of Oral Health in U.S. Employed Adults and Seniors: 1985-1986. National Findings. US Government Printing Office, NIH Publication No. 87-2868, August, 1987.

Epidemiology and Oral Disease Prevention Branch, National Institute of Dental Research, National Institutes of Health, DHHS. Prevalence of Dental Caries in U.S. Children, 1986-87. Unpublished Data.

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Institute of Medicine. The Future of Public Health. Washington, DC: National Academy Press, August, 1988. Preface and Summary, Prepublication copy.

National Institute of Dental Research, National Institutes of Health, DHHS. Research and Action Program for Improving the Oral Health of Adults and Older Americans. 1988.

Public Health Service, Department of Health and Human Services. Promoting Health/Preventing Disease: Objectives for the Nation. US Government Printing Office, 1980. "Fluoridation and Dental Health," pages 51-55.

Public Health Service, Department of Health and Human Services. Surgeon General's Workshop on Health Promotion and Aging. Proceedings. Menlo Park, CA: Kaiser Foundation, 1988. "Recommendations of the Dental (Oral) Health Working Group," pages 60-63.

APPENDIX D

AN INVENTORY OF RESOURCES AND ACTIVITIES DEVOTED TO DENTAL AND ORAL HEALTH

IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 1989

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EXECUTIVE SUMMARY

OVERVIEW AND APPROACH

This report presents the findings of a short term project, ***Comprehensive Inventory of Dental and Oral Health Activities within the Department of Health and Human Services***, sponsored by the Office of Planning and Evaluation of the Health Resources and Services Administration of the Public Health Service. The project was completed under Contract Number HRSA 88-650(P).

The purpose of this 12 week project was to:

- Produce a comprehensive inventory of dental and oral health activities within the Department of Health and Human Services;
- Compare current activities with those identified in previous inventories conducted by the Department; and,
- Prepare a report on this information that can be used during the deliberations of an internal Dental Policy Advisory Committee established to advise on, among other subjects, the preparation and submission of a report to Congress, as requested by the Committee on Appropriations (HR 100-256).

The Congressional request was prompted by a concern on the part of the Appropriations Committee that '...***the successful translation of (research findings) into better health for the American people may not be as well organised or as effective.***'

The request called for the establishment of a Dental Study Committee consisting of public and private sector representation to report to Congress on '...***appropriate goals and priorities in dental health in the areas of research, education, prevention and service***' and that they '...***consider appropriate organisational and administrative arrangements for achieving maximum coordination and effectiveness of dental health activities within the Department.***'

This project was initiated on August 30, 1988 with a meeting between the project staff, the Project Officer, the Director of HRSA/OPEL, the Chief and Deputy Chief Dental Officer, and dental personnel from the Indian Health Service Dental Branch, the National Institute of Dental Research, and the Centers for Disease Control.

The HRSA Project Officer for the project was Dr. Pearl Perry, of HRSA/OPEL. Continuing dental inputs to the project have been provided by Dr. William Maas, Dental Services Branch, Indian Health Service.

To obtain the data required for the report, a survey of agencies throughout the department was completed. The survey was disseminated to all Department agencies under the auspices of the Office of the Assistant Secretary for Health, Dr. Robert Windom. Each agency was asked to appoint a contact person to coordinate the dissemination and completion of surveys by all offices with dental activities. The authors would like here to thank the many people throughout the Department who cooperated in completing the survey in a relatively short time period. The completion of this study within a 3 month period is attributable largely to the cooperative spirit shown by the agency staff in providing the basic data.

The survey was supplemented by interviews with especially knowledgeable persons throughout the department and members of the American Dental Association (ADA) and by review of the several prior reports completed for similar purposes in the past. Supplemental information on current staffing levels of dental professional personnel was also provided by the office of the Assistant Secretary for Personnel Administration.

To establish a base of programs, the Federal Catalog of Domestic Assistance was reviewed and combined with information gleaned from the previously completed Department surveys of dental activities.

SUMMARY

This report is intended mainly to be used as input data for the deliberations of the Committee established for the purpose of advising on the Congressional report. It is not intended as a policy document, or even a policy advisory document. The report presents factual information, as that information has been made available to the authors through interviews and the survey data. In some cases, the survey respondents elected not to provide any new data and outside data sources were used, where available.

In attempting to draw comparisons with earlier years, the inevitable difficulties were faced; the prior studies covered the subject in slightly different ways and thus the data are not always strictly comparable. Comparisons were drawn when they seemed to be warranted.

The report provides:

- background information and a context for considering dental and oral health goals and objectives as well as changes in federal dental health initiatives and activities;
- a historical overview of the organization and nature of dental health related activities in the Department;
- a review of current dental activities based on the 1988 Department-wide inventory and supplemented by other written documents and phone contacts; and,
- a comparison of current dental activities with those identified in prior studies.

Although many changes have occurred over the period covered by the several reports included in the Chapter describing the comparative data, a few changes appear to characterize the shifts over time.

- Many program budget categories show substantial reductions over the past ten year period, although research funding has grown over the same period, with the NIDR research budget (adjusted for inflation) showing a modest growth of about 4.5% over a ten year period. The growth in research funding reflects in part the changing nature of dentistry and the status of oral health, as it shifts from its earlier emphasis on prevention and treatment of dental caries to a growing emphasis on the prevention and control of periodontal and other oral diseases.

- Manpower education and training shows a substantial reduction and a shift from general forms of aid, such as capitation grants to dental schools, to more highly focused assistance programs, targeted on minorities and other selected priorities. The profound reduction in Federal support in this area is accompanied by the substantial growth trends in availability of practicing dentists throughout the country, suggesting far less need than in the past for growth stimulants such as Federal aid.

- Funding for services in general appears to be up substantially from prior periods, although here the data base is not as complete as it should be for valid comparative purposes. The two major areas of apparent growth are funding for the Indian Health Service and funding for Medicaid. After adjusting for population growth and inflation, however, the IHS has merely maintained its program relative to the needs of its beneficiaries, while the amount of services provided by the Medicaid program has declined significantly.

- Total staffing of dental professional positions appears to be on a downward trend generally, aside from IHS dental staffing which shows an increase over the past fifteen years. Much of the reduction in staffing accompanied a reduction in the number of programs in existence and the number of organizations within the Department with a dental program activity.

- Perhaps the most visible change over the past ten years can be seen in the current absence of any organizational locus for dental policy within the Department. The staffing reductions which accompanied the elimination of many offices within PHS, has led to a fracturing of dental activities and policy, such that it is now difficult to find any central unit which can lay claim to Dental Policy as its mission. Both the Chief Dental Officer and the Deputy Chief Dental Officer occupy full time positions of importance, as the Director of the Bureau of Maternal and Child Health and Resources Development, and the Deputy Director of NIDR, respectively. Thus, their ability to provide the policy focus is constrained by their other duties. Whether the absence of such a unit is viewed as problematic depends on one's sense of Federal responsibility in this area.

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June 27, 1989

Senator Don Reigle
U.S. Senate
Dirkson Office Blgd.
Washington D.C. 20510

Sen. Reigle:

Thank you for the opportunity of allowing Dental Survey of America to submit written testimony on public hearings for uninsured American people. We hope that our comments will be helpful in identifying issues to be addressed in any pending legislation.

We have been in contact with your legislative staff person Ms. Debra Chang and have informed her that as of the direct result of our research, Congressman Lewis Stokes, in February 1989 requested a full review of medicaid dental programs. On April 17, 1989, we received notification sign by Congressman John Dingell, Chairman, Committee on Energy and Commerce adjoin with Congressman Henry A. Waxman Chairman, Subcommittee on Health and Environment requesting Dr. John H. Gibbons, Director, Office of Technology Assessment to conduct a study on dental care provided under Medicaid.

We have enclosed copies of documents that were instrumental in launching the study of dental care under medicaid. Please feel free to copy and distribute the reports as necessary.

Thank You

Norman J. Clement DDS
Chairman, Dental Survey of America

DENTAL SURVEY OF AMERICA

THE TOOTHGATE SCANDAL

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June 27, 1989

EXECUTIVE SUMMARY

Dental Survey of America was founded in January 1988 by a group of Dentist who are graduates of the University of Michigan School of Dentistry. Our goals are to conduct research and promote forums on dental public health policy. We are submitting this summary along with the attached exhibits as written testimony to be included in the Senate records on the public hearing on health care for the uninsured American.

We feel **Dental Care is Health Care** and this segment of health care has been long overlooked. According to a recent Department of Health and Human Services Study released on May 16, 1989 to the House and Senate Appropriation Committees by the Chief Dental Officer of the United States, Assistant Surgeon General Dr. Daniel F. Whiteside called Improving the Oral Health of the America People: Opportunity for Action, it states, " Oral disease diseases present a greater threat to systemic health. Most notably, approximately 30,000 persons develop cancers in the oral cavity or pharynx each year, and 9,400 people die. Nor can one afford to overlook the relation between oral and general health. ***No person can be considered healthy when active disease persist in any part of the body***. In addition, some systemic diseases, such as diabetes, rheumatoid arthritis, and heart valve disease, have effects on, and are affected by, the oral tissues or their treatment." There are many in government who are currently advocating placing Americans lacking health insurance on to medicaid. While we considered this attempt noble, our study called the The Toothgate Scandal clearly demonstrates that nearly all state run medicaid programs places their current recipients general and dental health specifically in imminent danger.

We have compiled and reviewed State Medicaid Dental Provider Manuals to assess their current appropriateness in providing guidance to the conduct of these State programs and in assuring quality dental care for eligible beneficiaries.

Dental Survey of America began a comprehensive comparative study in January 88 of our nation's Medicaid Dental Program.[1] Dental Survey of America obtained copies of some 46 State medicaid dental program manuals and compared whether policies and procedures in these programs and manuals were consistent with Dental Health Care policies established by the federal government and national organizations. [2] Dental Survey of America began to identify two very distinct interrelated problems with the medicaid dental program:

> 1. In several programs, policies and procedure definitions were inconsistent with the nomenclatures used in modern dentistry and some procedure definitions were found to be incomplete or otherwise incorrectly based on current accepted dental practice.[3]
>
> 2. Many investigators assigned to Medicaid Fraud Control Units are neither competent, knowledgeable nor qualified in the area of health specialties they are designated to investigate and oftentimes use outdated, outmoded policy and procedure manuals for the interpretation of provider fraud and abuse.

Under the medicaid program, the federal and state governments share the cost incurred by states in providing medical care to persons unable to pay for such care. This program authorized by title XIX of the Social Security Act, began in 1966. Each State's Medicaid agency is responsible for designing and administering its program.[4]

In some programs Medicaid officials had uniquely designed policy and procedure manuals which made no sense and made it nearly impossible for any dental providers to be reimbursed for their services. Oral health care providers in every state have complained that Local medicaid agencies frequently change rules making some procedure guidelines impractical to treat a child on medicaid. Medicaid Policy Review Boards and Committees required by Early Periodic Screening Diagnosis Treatment (EPSDT) legislation to review Dental Policies as set forth in program manuals were found in several states to be ineffective or non-existent.

Providers have increasingly been frustrated with medicaids' multitude of problems especially archaic reimbursement patterns, electing to instead terminate their status as medicaid providers. There is overwhelming evidence that many of these States have deliberately changed these rules to save money at the expense of the patients' care and the providers of that care. Arbitrary decisions, often not in the patient's best interest are made by public health dental consultants whose individual opinions are not easily challenged.[5] It has become evident that medicaid clearly is a program operating outside the practice of modern dentistry and in all but a few states, local Dental Organizations and Boards of Dentistry; had very little input in the final policies written for State-run Medicaid Dental Program Manuals.[6]

Its been recorded that on June 24, 1986 at the 90th annual convention of the Florida Medical, Dental and Pharmaceutical Association, several dentists requested to serve on the committee responsible for writing the Florida medicaid dental manuals. Morine Funderburk, Program Policy Director for the Florida's Medicaid Program, Department of Health and Rehabilitative Services **(HRS)** gave the following response:

> " We don't have a Committee now, what we have is a loose sort of ***thing*** between this consultant here and that consultant there. There has been talk about a committee but we haven't gotten around to that sort of thing yet."[7]

However Federal Medicaid EPSDT regulations requires under 42 CFR SECTION 441.56 (b) (2) 1985 that:

> ...states consult appropriate professional organizations in the development of schedules for periodic visits and within them screening packages.[8]

The intent of this requirement was to ensure that states fashioned EPSDT-Medicaid programs which reflect reasonable standards of dental and medical practice.[9]

Dental Survey of America investigated and found that the training received by fraud investigative personnel consisted of either on-the job training (with no medical or dental backgrounds) or a three to seven day training course sponsored by municipal organizations. It was also found that fraud units relied heavily on policies in program manuals and opinions of public health dental consultants. Program manuals, of policies and procedures were found to be so technically flawed that no case of medicaid fraud should have or could have been brought against any Dental Medicaid provider in some states. According to James R. Hayward DDS, MS, University of Michigan Emeritus Professor and Chairman Department of Oral & Maxillofacial Surgery "It is quite obvious that no self-respecting dentist could ever conduct their practice at the dictates of medicaid." [10]

In congressional testimony before the House Appropriations Committee and Senate Special Committee on Aging, several Medicaid Fraud Control Units had reported that once providers became aware of ongoing investigations on them or other providers in the same geographic area or provider specialty, their Medicaid billings decreased. The analysis included a review of changes in providers' Medicaid billing patterns or changes in Medicaid payments to providers as indicators of deterrence before, during, and after fraud units investigations.[11]

Dental Survey of America uncovered serious evidence indicating that many fraud units utilized investigative methods, tactics, and statistical analyses that were questionable and possibly illegal. Moreover this study clearly established that much of the exhortations made by fraud unit's regarding their deterrent effects have been grossly overstated and possibly erroneous.

Providers frequently verified that their first realization of an investigation occurred when fraud units began to harass and intimidate patients and employees affiliated with their operation.[12,13,14,15,16] Several Florida Dentists reported frequent calls from patients complaining of visits to their homes and jobs by fraud investigators. These patients reported having been told that their dentist was engaging in fraudulent activity, and these same investigators were encouraging their patients to find another dentist.[17,18,19] One Dentist also reported to DSA that one of his former denture patients had called his office and stated she was approached by fraud investigators in her yard and asked to remove her denture.[20] This Dentist stated, "I noticed a significant drop in patients on medicaid making appointments with my office."

Dental Survey of America has gone on to publish four articles in less than one year concerning these morally appalling standards found in our nations medicaid dental program manuals (see exhibit A,B,C,D,E,F). As the direct result of our research, Congressman Lewis Stokes, in February 1989 requested a full review of medicaid dental programs(see exhibit G). On April 17, 1989, we received a letter sign by Congressman John Dingell, Chairman, Committee on Energy and Commerce adjoin with Congressman Henry A. Waxman Chairman, Subcommittee on Health and Environment requesting Dr. John H. Gibbons, Director, Office of Technology Assessment to conduct a study on dental care provided under Medicaid(see exhibit H). Two days later the study was begun(see exhibit I). Dental Survey of America has been in direct contact with Congressman John Conyer's of Detroit Chairman of the House Government Operations Committee who has begun a second investigation on the activities of Medicaid Fraud Control Units based on information received from DSA and health care providers all over the country (see study).

Hapless, mismanagement by state officials in zeal to prosecute oral health care providers even on the most minuscule of error including errors admittingly caused by the local state run medicaid agency has resulted in a significant number of dentists finding themselves on the **right side of dentistry but on the wrong side of the law**. This tragic set of bureaucratic bugling on the federal level explains why Dental Survey of America found in its review of State medicaid program manuals dental, policies and procedure varying so widely that what may be standard practice of dentistry in one state could be felony fraud in another. The hopes that local dental organizations and boards of dentistry can provide input into these programs to the standard care of dentistry has long past. Some state programs have become so indifferent to the practice of dentistry, Federal guidelines as set forth by Congress for the Administering of Medicaid Dental Programs and latent with corruption that the only way to effectively resolve this crisis is through Congressional Oversight and Investigation. This must then be followed by indictments and vigorous criminal prosecution of these local state medicaid officials by the U.S Justice Department.

END NOTES

1. "**Why Poor Johnny Doesn't Smile**," Journal of Pedodontics Vol.13, Number 1 Fall 1988 pg. 1 Norman J. Clement DDS et. al.

2. IBID

3. American Dental Associations Council of Dental Care Programs review of the Florida Medicaid Program Manual, January 13, 1987, letter from Jasna Stocic to Norman J. Clement DDS.

4. United States General Accounting Offices, GAO/HRD-87-12FS, October 1986, Page 6.

5. IBID, pg.8

6. IBID, pg 1

7. June 24, 1986, Florida Medical Dental and Pharmaceutical Associations 90th meeting, Ramada Inn North, Tallahassee Florida, Dental Continuing Education Program, Florida Medicaid HRS/EDS, Morine Funderburk, Yolanda Rivera, Lois Coker, videotape 1hr. 24min..

8. Maximizing The Use of the EPDST Program in the Delivery of Dental Care to Low-Income Children by Kay A. Johnson, M.P.H., M.Ed. of the Children's Defense Fund, 122 C Street N. W., 4th Floor, Washington D. C. , 20001. A paper prepared for the American Public Health Association Annual Meeting in Las Vegas, 1986.

9. IBID.

10. James R. Hayward DDS letter to Norman J. Clement DDS, January 11, 1987.

11. Medicaid, Results of Certified Fraud Control Units(GAO/HRD-87-12FS)page 12.

12. State of Michigan vs. Reginald Henderson CEO., Quality Clinical Laboratories

13. State of Florida vs. Willie Sherman

14. State of Florida vs. Mike Battles

15. State of North Carolina vs. Reginald Hawkins

16. State of NewYork vs Mike Davidson DDS

17. State of Florida vs. Willie Sherman DDS.

18. State of Florida vs. Mike Battles DDS.

19. State of North Carolina vs. Reginald Hawkins DDS.,

20. State of Florida vs Norman J. Clement DDS, Patients Ellord and Willie Sherrod.

"EXHIBIT INVENTORY"
from Dental Survey of America
Submitted as written testimony on
Public Hearings on the Uninsured
held in Southfield Michigan June 28,1989
by Senator Don Reigle

A. "Why Poor Johnny Doesn't Smile." March 30, 1988. by Norman J. Clement DDS, Published Copyrighted October 88, Fall edition of The Journal of Pedodontics.

This article was the first Preliminary Comparative Review of a Report from Dental Survey of America on State Medicaid Dental Programs by Norman J. Clement DDS. (Accompanied by videotape called **"Why Poor Johnny Doesn't Smile"**

B. "How The Medicaid Dental Program in America is a National Disgrace." THE TOOTHGATE SCANDAL. August 15, 1988 by Norman J. Clement DDS, Daryl E. Williams DDS., MS., Dalton Sanders DDS. Published Copyrighted December 88, Winter edition of The Journal of Pedodontics.

This was the first pilot report, and the first comparative study ever done of Dental Medicaid Provider Manual on a State by State basis in the United States. The principle findings of this report are that 96% of the Medicaid Dental Programs are **substandard** and present a **IMMINENT DANGER** to medicaid recipients and their dentists.

C. " Comparative Review of the Florida Medicaid Dental Provider Manual" December 15, 1988 by Norman J. Clement DDS, Daryl E. Williams DDS., MS., Dalton Sanders DDS. Published Copyrighted December 88, Spring edition of The Journal of Pedodontics.

This article documents how dentists who questioned or challenged dangerous medicaid policies or procedures are threatened, sanctioned, indicted, fined or imprisoned by State Medicaid Officials using the criminal justice system. It further points out that the American Association of Oral Maxillofacial Surgeons, the Auditor General for The State of Florida ,the Dental Survey of America and noted Oral Maxillofacial Surgeons such as Raymond J. Fonseca DMD chairman of the Department of Oral and Maxillofacial Surgery University of Michigan along with a host of practicing dentists who have been victimized by State Medicaid dental policies agree that substantial changes must be made in the interest of the dentist and the patient.

D. " Comparative Review of the Ohio Medicaid Dental Provider Manual" March, 1989 by Norman J. Clement DDS, Daryl E. Williams DDS., MS., Dalton Sanders DDS. Published Copyrighted March 89, Summer edition of The Journal of Pedodontics.

E. THE LAWYER DENTIST RELATIONSHIP, PART 1. ON REVIEW OF MEDICAID DENTAL PROGRAMS FOR ATTORNEYS. **STUDY BY DENTAL SURVEY OF AMERICA ON MEDICAID DENTAL FRAUD**, submitted for publication April 23, 1989 to the Journal of the National Bar Association, by Norman J. Clement DDS, Daryl E. Williams DDS., MS., Dalton Sanders DDS.

This is a two part series by dentists to familiarize Attorneys with standard dental procedures and terminology to aid them in case preparation for court room presentation. .

E. *DEPARTMENT OF HEALTH AND HUMAN SERVICES*
STUDY:Improving the Oral health of the American People Opportunity for Action. (Dental Survey of America submitted written testimony)

A report highly critical of Dental health policies in America was issued May 16th to the Congress. The report states," Improved oral health for all Americans has been constrained, in large part, by the low priority and visibility afforded oral health activities at the Federal Level." The Study found Departmental dental activities to be fragmented, lacking and uncoordinated, preventing DHHS from effectively carrying out its responsibilities. Most importantly, studies says "it was unable to identify within the Department either a discernible oral health policy, or mechanism whereby oral health perspectives are assured of receiving appropriate consideration in the development of health policies."

G,H I,J: Congress to probe The Toothgate Scandal

As the direct result of our research, Congressman Lewis Stokes, in February 1989 requested a full review of medicaid dental programs. On April 17, 1989, we received a letter sign by Congressman John Dingell, Chairman, Committee on Energy and Commerce adjoin with Congressman Henry A. Waxman Chairman, Subcommittee on Health and Environment requesting Dr. John H. Gibbons, Director, Office of Technology Assessment to conduct a study on dental care provided under Medicaid. Two days later the study began.

K. ARE MEDICAID FRAUD CONTROL UNITS THE REAL FRAUD ?
PART-1, STUDY BY DENTAL SURVEY OF AMERICA ON MEDICAID DENTAL FRAUD.

BY NORMAN J. CLEMENT, DDS, DARYL E. WILLIAMS, DDS., MS DALTON P. SANDERS, DDS. Published Copyrighted March 89, Summer edition of The Journal of Pedodontics.

This study was prompted as the result of a growing number of dentists having found themselves under indictment on charges of medicaid dental fraud for dollar amounts of less than $500.00 by these fraud units. We reviewed the investigation methods and tactics used by fraud units to obtain indictments against dentists and other health care providers. We also reviewed the training, qualifications, and backgrounds of investigators assigned to Medicaid Fraud Control Units.

L. THE TOOTHGATE SCANDAL, HOW THE STATE OF FLORIDA'S DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES HAVE OPERATED THE MEDICAID DENTAL PROGRAM(EPSDT) ILLEGALLY,

SECOND IN COMPARATIVE REPORT FROM DENTAL SURVEY OF AMERICA
by NORMAN J. CLEMENT DDS DARYL E. WILLIAMS, DDS., MS
DALTON P. SANDERS, DDS. **DRAFT** to be submitted to The Journal of Pedodontics.

Dental Survey of America found what appears to be the delibrately and willful intent on apart of officials managing the Florida medicaid dental program to maintain policy and procedures that are substandard with Children's Dental Health Care.

LOUIS STOKES
21ST DISTRICT, OHIO

COMMITTEE ON APPROPRIATIONS

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ON INTELLIGENCE

CHAIRMAN,
SUBCOMMITTEE ON BUDGET AND
PROGRAM AUTHORIZATION

Congress of the United States
House of Representatives
Washington, DC 20515

February 16, 1989

The Honorable Henry Waxman
Chairman
Energy and Commerce Subcommittee on
Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Henry:

I am writing to request that the Energy and Commerce Health Subcommittee conduct a full review of the adequacy of Medicaid dental practice standards as set forth in the manuals by the federally-funded state Medicaid programs.

Over the past year, my office has been working with a group of dentists who are concerned about whether current Medicaid dental practice standards are consistent with standards approved by organized dentistry. As you know, Medicaid enables low-income and disabled persons, or members of families with dependent children, to receive medical and dental care. According to the Health Care Financing Administration (HCFA), in 1987, 22.1% of all services rendered through Medicaid were for dental care. Of the total Medicaid population who received dental services, 9.6% were children served through the Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT). It is alarming to think that some of our nation's neediest individuals might be receiving substandard care through the Medicaid program.

In this regard, I encourage your immediate attention to this matter. In a nation that has achieved unprecedented success in the health field, it is unconscionable to think that millions of Americans are not receiving quality care.

I look forward to hearing from you on this important matter.

Sincerely,

LOUIS STOKES
Member of Congress

LS/lla

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WM. MICHAEL KITZMILLER, STAFF DIRECTOR

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515

April 17, 1989

Dr. John H. Gibbons
Director
Office of Technology Assessment
600 Pennsylvania Avenue, S. E.
Washington, D.C. 20003

Dear Dr. Gibbons:

We wish to request that the Office of Technology Assessment (OTA) conduct a study on dental care provided under Medicaid, as described below.

The study should ascertain whether the dental care provided to Medicaid beneficiaries, particularly to children eligible for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, conforms to the standard norms of dental practice. For the purposes of this study, dental care guidelines issued by federal agencies (e.g., the Health Care Financing Administration dental guidelines for the EPSDT program) and dental professional groups (such as the American Dental Association, and the American Academy of Pediatric Dentists) suggest a minimum standard of dental care.

The study should evaluate a representative sample of five or six State Medicaid programs, chosen by OTA, for their conformance with a minimum standard of dental care, as defined in Federal and professional guidelines. The study should also include, if possible, some measure of the actual dental care received under the State programs. We understand that surveying the actual provision of services may not be possible given your resources, but we hope that any such data already available can be utilized whenever feasible and that surrogate measures can also be identified to the fullest extent possible.

Our staff have been in contact with Pamela Simerly and Clyde Behney of OTA's Health Program concerning this request. We look forward to your response.

Sincerely,

John D. Dingell
JOHN D. DINGELL
Chairman, Committee
on Energy and Commerce

Henry A. Waxman
HENRY A. WAXMAN
Chairman, Subcommittee
on Health and the Environment

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Congreſs of the United States
OFFICE OF TECHNOLOGY ASSESSMENT
WASHINGTON, DC 20510-8025

JOHN H. GIBBONS
DIRECTOR

CHILDREN'S DENTAL SERVICES UNDER THE MEDICAID PROGRAM

April 1989

PROJECT DESCRIPTION: In 1972, Medicaid began a comprehensive health care program specifically for children. This program, the Early, Periodic Screening, Diagnosis and Treatment program (EPSDT), provides for "early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and treatment to correct or ameliorate defects and chronic conditions found" (42 CFR 441.50). Dental services, both preventive and therapeutic, are specifically included in the EPSDT legislation.

This study will compare the types of dental services delivered and offered under EPSDT with minimum acceptable standards of dental care as defined by Medicaid program guidelines and the dental profession. The study will not quantify all problems, their severity, or their impact. Nor will it examine more global problems within the EPSDT program, such as access to care, reimbursement issues, or eligibility requirements, although such problems must impact on the dental care delivered.

Study Sample: The study will include a sample of States, including States with large Medicaid populations and States with high and low payments per beneficiary in the Medicaid program. The following States may be included in the sample: California, New York, Michigan, Ohio, Mississippi, Texas, and Nevada.

Method of Study: National EPSDT dental care guidelines will be compared with guidelines issued by the dental profession and other Federal agencies concerned with the dental health of children. A set of dental care components shared by these guidelines will be identified as the minimum care that should be provided. Note that this will be an assumed level of minimum care, not one that has been assessed for medical necessity by OTA. This set of minimum dental care components will be reviewed by outside experts (including Federal and State Medicaid officials, dental societies and associations, individual dentists, and others). The minimum components will then be compared with each sample State's dental Medicaid manual. These comparisons will provide information about the level of dental care that is allowed under each State's Medicaid program. To the extent possible, the study will also explore the level of dental care actually received by children enrolled in EPSDT.

REQUESTED BY: The study has been requested by the House Committee on Energy and Commerce, Congressman John Dingell, Chairman, and its Subcommittee on Health and the Environment, Congressman Henry Waxman, Chairman.

TIMING: The study began in April 1989 and is scheduled for completion in the Fall of 1989.

OTA STAFF CONTACT: Pamela Simerly, Study Director; or Paula Chludzinski, Research Assistant. Telephone 202/228-6590.

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Congress of the United States
OFFICE OF TECHNOLOGY ASSESSMENT
WASHINGTON, DC 20510-8025

JOHN H GIBBONS
DIRECTOR

May 26, 1989

Norman J. Clement, DDS
Dental Survey of America
20060 Santa Barbara
Detroit, MI 48221

Dear Dr. Clement:

As I promised you in my last letter, here is our draft of a set of core dental guideline components for your review. This draft represents the compilation of common components from several sets of dental guidelines, including those suggested by the Health Care Financing Administration (HCFA), the Public Health Service (PHS), the American Dental Association (ADA), and the Office of Disease Prevention and Health Promotion (ODPHP). In all instances, the most minimal aspect of a shared component was selected (e.g., that a child should receive an annual exam, rather than exams twice a year), since the rationale behind compiling a common set of components is that such a set would represent the core of a set of dental services that any child should receive. Remember that the purpose for compiling this set is to ascertain the level of care provided for by State Medicaid programs, and not to design an optimal dental care program. (For your convenience, I've also included another copy of the project description in this packet.)

The draft that you have received is arranged in three columns. The first column contains ADA Procedure Codes when we thought they appropriately described the corresponding service. However, I have attached a copy of the ADA Code, for your reference, in case we have made coding errors. The second column describes components from HCFA's Medicaid Manual for dental care under EPSDT (1988) or the EPSDT dental guidelines issued by HCFA (1980)--two separate documents. Not all of the original guidelines we consulted contained the HCFA/EPSDT components, as evidenced in column three. While there were other components not included in the HCFA/EPSDT set (e.g., individual crowns, oral surgery), they were not commonly shared by all the other guideline sources and so were not included in the standard set.

It is important to keep in mind that this draft set is not comprehensive, so comments you might have regarding missing components are not especially useful. However, all comments are welcome, especially those related to the accuracy with which we have portrayed the original guidelines in our compiled draft set. Any comments you may have about the study in general are also appreciated. Also, please feel free to suggest others to review this document.

Most importantly, though, comments that you can provide to Paula Chludzinski or me by the week of June 18 will be the most useful. I have also enclosed a postage-paid envelope with our address on it, for your convenience, should you choose to respond by mail. We can also be reached by telephone at 202/228-6590 or by fax machine at 202/228-6098. Unfortunately, I will not be available from June 2 to June 12, but Paula will be here to answer questions or to take your comments should you call during that week. We look forward to hearing from you.

Sincerely,

Pam Simerly

Pamela Simerly
Study Director

OHIO DEPARTMENT OF HUMAN SERVICES
COMPARATIVE
REVIEW OF THE STATE OF OHIO
MEDICAID DENTAL PROGRAM

NORMAN J. CLEMENT DDS.
DARYL E. WILLIAMS DDS. MS.
DALTON SANDERS DDS.

INTRODUCTION

Dental Survey of America, conducted a comparative review of State-run Federally Funded Medicaid Dental Programs Manuals throughout the country. Dental Survey of America is a national organization which promotes research and forums on Dental Public Health Policy and is made up of graduates of the University of Michigan School of Dentistry.

It appears nearly all State run federally funded Medicaid Dental Programs Fail to meet the **minimal** standards for Dental care in this country as recommended by national established Dental organizations. We found that nearly all State run federally funded Medicaid Dental Programs were in **Non compliance** with their own State regulations governing the practice of Dentistry and also were in **violation** of Federal guidelines as set forth by Congress for the Administering of Medicaid Dental Programs. Almost 96 percent of State run federally funded Medicaid Dental Programs Manuals which we reviewed had Dental policies and procedures that were either inconsistent, or incorrect, and some had dental procedure that were **non existent** in the current practice of modern Dentistry.

The Ohio Medicaid Dental Program is but one more sad example of where States appear to have deliberately designed policies and procedures (P&P)inconsistent & incorrect with the current practice of Dentistry. Quite tragically there are no provisions in the Ohio Medicaid Dental Manual for the prevention and treatment of Dental Disease and neither are there any meaningful provisions for the restoration of the Oral Cavity as the result of Dental Disease.

In 1969 provisions for early identification and treatment of physical and mental defects in children which required Early and Periodic Screening, Diagnosis, and Treatment(EPSDT) for all medicaid eligible under the age 21.[1] Later in1972 and in 1985 the Congress passed additional amendments which imposed penalties for those states that did not implement the EPSDT program. These two legislative action no longer made Dental treatment optional but mandatory.[2] The affirmative action requirement of the Medicaid EPSDT program was originally added to the **Social Security Act in 1972** in response to growing Congressional concern over states' failure to implement EPSDT.[3] Federal law requires under 42 CDF Section 441.56 (c) (2) that:

> "all Dental Care as early an age as necessary which is needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," States will be cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT).[4]

As with nearly all of the medicaid program Dental manuals the Ohio medicaid Dental manual is beseige with technical error making it difficult for any Dentist to provide any meaningful Dental care to medicaid recipients. Ohio Medicaid Program Officials have all but ignored the intent of Congress which under Title XIX of the 1965 Amendments to the Social Security Act helped states pay for health care for eligible people and to provide the services to help people become more self-sufficient and better able to lead normal and productive lives. So flagrant are the violation in the Ohio Medicaid Program to the practice of dentistry in the Ohio Medicaid Program Provider Manuals that one can only assume that those official who were responsible for putting these manuals together willfully, deliberately and intentionally designed program P&P which fail the practice of Dentistry in the treatment of dental disease in its amount, scope and duration. Federal Medicaid regulation **42 CFR Section 440.230(b) 1985.** requires that the state plan specify care that is reasonable in:

> "amount, scope and duration"[5]

Dental Survey of America(DSA) finds it nearly impossible to believe how anyone knowledgeable in the field of Dentistry or any Dental Consultant could have ever signed off an approval on the Ohio Dental Provider manuals. DSA found evidence that Ohio Medicaid officials were repeatedly warned by the Local State Dental Society and other concerned Dentist chief among them Dr. Donald Bowers a Pedodontist and currently Director of Admissions at Ohio State University College of Dentistry that there were serious flaws in the Ohio Dental Medicaid Provider Handbook Chapter 3335 which presented a **IMMINENT** danger to the health care of medicaid recipients. Federal Medicaid EPSDT regulations requires under 42 CFR SECTION 441.56 (b) (2) 1985 that:

> "states consult appropriate professional organization in the development of schedules for periodic visits and within them screening packages."[6]

The intent of this requirement was to ensure that states fashioned EPSDT-Medicaid programs which reflect reasonable standards of dental and medical practice.[7] In the State of Ohio to this date medicaid officials have all but ignored the recommendations and warnings by the appropriate professional dental Organizations. Dental Survey of America believes that such intransigence of the State to adhere to federal guidelines and to clearly operate their program outside the practice of Dentistry warrants a probe into possible criminal wrong doing on apart of Ohio Medicaid Program Officials both past and present. The Federal District Court of Appeals for the fifth Circuit ruled in Mitchell v Johnston cite as 701 F.2d 337(1983) pg 338, that:

> "When state voluntarily and knowingly accepted terms of Federal-state "contract", state is required to fulfill it Mandatory obligation under the contact.[8]"

The Ohio Medicaid Dental Program is quite different from any other program manual we reviewed by prohibiting the listing of fee schedules on payment of services provided under its program. In speaking with Dentist throughout the State of Ohio many of them felt that it was not worth their while to become providers on the medicaid programs because there was no assurance on when or what they would be paid. DSA also found there was great bitterness toward the program and the clients chiefly from Dentist who rendered service and were either not paid or expressed the extreme difficulty in getting paid. All the Dentist we spoke with agreed that the arrogance on apart of medicaid official to come up with a more applicable fee schedule to assure on time payments and policies and procedures (P&P) consistent with the practice of Dentistry served as a deterrent to providing Dental services on poor persons eligible under the Ohio Medicaid program. Kay Johnson, MPH, Med., Senior Health Specialist with the Children"s Defense Fund, found that many States have used low fee schedules & slow reimbursements to discourage provider participation thus resulting in low utilization and a saving for the States budget.[9]

The Ohio Medicaid Dental Program is but one more small piece of a very large puzzle in this comparative study of State Medicaid programs by Dental Survey of America which clearly demonstrates that State run Medicaid Dental Programs are a National Disgrace.

RESTORATIVE

Our review of this section in the Ohio Dental Medicaid Program clearly shows how services are made inferior by policies and procedures that are incorrect and inconsistent with the practice of Dentistry. The below procedure for Composite restoration found under Dental Services II. Covered Services and Associated Limitations Issued 1-4-88 Page II-6 demonstrate the confusion and danger some policies pose.

C. RESTORATIVE SERVICES

.Acrylic, plastic, or Composite Resin Restorations

The reference to Composite resin along with Acrylic, and plastic materials was extremely confusing to most Dental practitioners because many of them have never seen an acrylic or plastic being used as a permanent restoration(filling). To the Dentist reference to a plastic restoration would be a layman term for a temporary crown. The acrylic restoration went out as a filling nearly 60 years ago in the 1930's. In fact just to demonstrate how confusing , incorrect and outdated the Ohio Dental Medicaid Manuals are, we took our first year dental school textbook, Principles and Practice of Operative Dentistry, Chapter 12, on Conservative Anterior Esthetics Restorations page 284-285, :

> Since early in the history of dentistry the matching of tooth color with a restorative material has been of concern. In **1878** Fletcher produced the first translucent cement, a dental silicate. Silicate cement did not immediately become popular, and wide-spread use began only with the introduction of improved German products in **1904**. The esthetics value of these silicate cements was highly acclaimed. However, some dentist were extremely critical because of pulpal damage and even pulpal death that often appeared to follow the placement of a silicate restoration. A variety of methods began to be employed for pulpal protection. Certain types of cavity liners seemed to reduce the effect of the phosphoric acid liquid on the pulp. Accordingly, the number and severity of pulpal problems diminished. Silicate cements had two factors in its favor. First, it was the only translucent filling material on the market and, second, it was relatively easy to match both the shade and translucency of the tooth being restored. Despite it deficiencies in physical and chemical properties, the dental profession made widespread use of Silicate cements.
>
> In the **1930's,** Germany developed a chemically activated tooth colored resin material. Following World War II, **chemically activated acrylic resins** immediately became popular. It was believed by many, and hoped by all, that at last here was a substitute for silicate cement. However, it was soon observed that these early acrylics materials lacked color stability, had a high degree of shrinkage during(setting) polymerization, and a high coefficient of thermal expansion that resulted in poor margin adaptation(if one ate hot or cold food the filling shrink and fall out). Thus, many Dentist discontinued their use and turned again to silicate cements.
>
> In 1962 Dr, Ray Bowen at the national Bureau of Standards developed the basic resin fora composite resin system which is now widely used for restoring tooth surfaces where esthetics is important. The composite or filled resin is composed of a continuous reactivated phase that is polymeric in nature and a discontinuous inert phase consisting of ground ceramic particles. The introduction of the ceramic material greatly improved the strength and reduced the coefficient of thermal expansion.

To this date States such as Michigan, Massachusetts, Florida, California, Montana, and Maine still advocate the use of Silicate cements as a restorative materials in their Medicaid Dental Programs. To the modern Dental Practitioner the use of a silicate or acrylic material as a permanent restoration would be equivalent to one prescribing Thalidomide as the drug of choice during pregnancy.[10]

CROWNS

The section below on crown restorations is a classic example how Ohio along with many other medicaid programs intentionally exclude necessary dental procedures and include other dental procedures which would be illogical and inconsistent with modern dental science.

. Crowns
*D2722 Plastic with metal
*D2752 Porcelain with metal

> "Porcelain with metal or plastic with metal crowns are authorized only for permanent anterior teeth."11

In the treatment of young adolescent teeth in particular the anterior(front) upper teeth the Porcelain crown be the treatment of choice. One of the first things which is taught in Dental School is that the heat and vibration induce by the use of highspeed dental instruments can be traumatic to the young immature permanent tooth. In Adolescents the size of the pulp is greater and the closeness in proximity of the final cavity preparation would warrant the dental practitioner to elect the more conservative porcelain crown preparation. The failure to include porcelain crown restoration defeats EPSDT guidelines. The court ruled in Mitchell versus Johnston that:

> "Absent the availability of porcelain crowns and with no other adequate available substitute, the preventive and restorative purposes of EPSDT are seriously compromised. Id. at 187."

Most Dentist and Dental labs we talked with had great difficulty understanding what a plastic with metal crown was but believed the manual may have been referring to veneer metal crowns which were very popular in the early 50's through late 60's. By today's standards plastic with metal crowns are inferior type crown restorations, very few good dental labs make them and the procedure is considered obsolete. The plastic or veneer material often times discolors, fractures and breaks off leaving to underlining gold matrix which is not a very esthetics material on Anterior (front) teeth.

Worst of all excluding porcelain metal crowns for posterior teeth defeats the purposes of EPSDT legislation. In Mitchell versus Johnston the Court concluded that:

> "evidence demonstrates that use of stainless steel crowns for children fourteen years or older may cause serious complications, including periodontal disease. Id. at 186-88."

ENDODONTIC

Dental Survey of America found the area of Endodontics was all but neglected and had the most technical errors in nearly all section of States manuals. We found some States all but ignored comprehensive endodontic therapy limiting services to pulpotomy and pulpectomy. As with most States we found no provisions in the Ohio Medicaid Dental Program Manual for the more conservative approach for salvaging Children and Adolescents teeth by the use of indirect or direct pulp capping. Frequently the majority technical errors occurred in the procedures for pulp capping , indirect and direct. In Florida's in HRSM 230-22, October 15, 1981 under pulp capping in Endodontic it states:

> "Pulp Cap. Pulp capping is differentiated from routine placement of a medication base or lining under a filling. The latter is included in the reimbursement for the restoration. Pulp capping may be separately reimbursed and is regenerative dressing over the exposed vital pulp. Both direct and indirect pulp cap is reimbursable."[12]

This by far was the most ludicrous definition Dental Survey of America found in all of its review medicaid program Dental manuals. The definition and use of indirect and direct pulp capping were found to be technically incorrect in every manual except for the State of Georgia, which placed limitations on the procedures that it discourages its use. In Ohio as with most States Dental providers because of the lack of policy are required to provide Substandard Care or NO CARE. Once again the difficulty is that the public lacking a understanding of Dental procedures would probably not know the difference. To the Dentist these policies would be equivalent to a Physician performing heart by pass surgery using a butter knife.[13]

Just to demonstrate how easy it was to correct the medicaid dental manual for the State of Ohio we simply found a basic Dental Textbook used by most Dental Students and looked up Indirect and Direct pulp- capping. The following are excerpts from Dr. Harold Gerstein's Professor and Chairman Department of Endodontics Marquette University School of Dentistry, textbook TECHNIQUES IN CLINICAL ENDODONTICS:

> Dental clinicians have argued that it is better to perform a pulpotomy to "be sure" of the results. However, because of the high rate of success possible with indirect pulp capping, in a large number of cases pulpotomy constitutes overtreatment.[14] Pulp capping is a procedure in which an exposed or nearly exposed pulp is covered with a protective dressing or cement that protects the pulp from additional injury and permits healing and repair and that indirect pulp capping is done in the absent of overt pain or periapical pathology and is a procedure in which the protective dressing is placed over a thin partition of remaining dentin or slightly soften dentin which, if removed, might exposed the dental pulp.[15]
>
> The clinical application of the indirect pulp capping technique may take one of three forms: caries control, a two-visit technique and a one visit technique.[16] Dimmaggio and Hawes reported in their study in which complete caries removal in 244 primary and permanent teeth with deep carious lesions but with no signs or symptoms suggestive of irreversible pulpitis resulted in an exposure rate of 75 per cent. They also showed in subsequent study that 99 per cent of primary teeth selected on the same basis could be successfully treated with indirect pulp capping.[17] Direct pulp capping has been considered the least desirable pulp therapy technique because of its unpredictable prognosis. It is indicated for mechanical exposure in primary and permanent teeth absent of spontaneous pain or periapical radiographic pathology. Many Dental clinicians do not use it for exposure in primary teeth but prefer to perform a pulpotomy, especially when exposure occurs while excavating caries. However, if it is reserved for carefully selected case of obvious mechanical exposures and if carefully performed, direct pulp capping can be a satisfactory treatment.[18]

There is no question that Ohio Medicaid officials were negligent when they constructed the Endodontic section of the Dental Provider Manual. Federal Medicaid EPSDT regulations requires under 42 CFR SECTION 441.56 (b) (2) 1985 that:

> "states consult appropriate professional organization in the development of schedules for periodic visits and within them screening packages."[19]

The intent of this requirement was to ensure that states fashioned EPSDT-Medicaid programs which reflect reasonable standards of dental and medical practice.[20] The below requirements are neither reasonable nor to they reflect standard dental practice. They certainly do reflect dental care in it amount scope and duration as required by Federal Medicaid regulation **42 CFR Section 440.230(b) 1985.** requiring that the state plan specify care that is reasonable in:

> "amount, scope and duration"[21]

Dental Survey of America(DSA) once again finds it nearly impossible to believe how anyone knowledgeable in the field of Dentistry or any Dental Consultant could have ever signed off an approval on the Ohio Dental Provider manuals. From the Ohio Medicaid Provider Manual Chapter 3335, Endodontics as seen below:

D. ENDODONTIC SERVICES

. Pulpotomy and Pulpectomy

D3220 Pulpotomy/Pulpectomy.

Pulpectomy or pulpectomy is a covered service only for recipients under age 21.

Pulpotomy and pulpectomy as separate procedures cannot occur in combination with root canal therapy.

The restoration for the complete pulpotomy or pulpectomy should be billed as a separate procedure.

In conclusion we then obtain a copy of A GUIDE TO DENTAL CARE **EPSDT-MEDICAID**, BY Roy L. Lindahl DDS, MS., Wesley O. Young, DMD, MPH., prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics under Contract SRS- 73-49, Social Rehabilitation Service, U.S. Department of Health, Education, and Welfare. This was the original document that was supposed to be use by the States in constructing their Medicaid Programs. Clearly one can see from these comparisons above and below that Medicaid was never a program design to operate outside the practice of dentistry. From A GUIDE TO DENTAL CARE **EPSDT-MEDICAID**.

VI. Restorative Dentistry

A. All carious material should be removed from a lesion before restoration except where indirect pupal therapy is indicated.

B. Acceptable procedures for the management of the pulp endangered by carious lesion or trauma include:

1. Indirect pulp treatment (capping).
2. Cavity liners and/or protective bases.
3. Direct pulp treatment (capping).
4. Pulpotomy.
5. Pulpectomy.
6. Root Canal filling.

C. The cavity preparation should meet currently accepted standards consistent with the requirements standards consistent with the requirements of the restorative material used.

D. The complete restoration should show adequate marginal adaptation and satisfy requirements of esthetics form and function.[22]

PERIODONTAL AND PREVENTATIVE SERVICES

Periodontal Services can be best described as confusing, vague, or non existent . No provisions appear to be made for basic periodontal service in Children and or Adults presented with periodontal disease of a Type II, III, or IV requiring periodontal scaling and root planning without which no meaningful type of Dental Care could ever proceed forward. The failure to include even the very basic periodontal services will ultimately result in the loss of the entire dentition from periodontal disease.

In Arizona as with Ohio the limitation placed on Periodontal Services and ridiculous fee schedules would deter any Dental Practice from treating any young patient presented with Acute Necrotizing Ulcerative Gingivitis(ANUG) or trench mouth. This condition generally found in children whose mouths are neglected requires Oral debridement with Hydrogen Peroxide, scaling and root planning, possibly Antibiotic therapy and always a follow-up visit.[23]

Periodontics

04910 Treatment for necrotizing ulcerative gingivitis......................$24.74[24]

We also took exception to the fact that procedure code **04910** is incoconsistent with the nomenclature in the American Dental Association's Code on Dental Procedures and nomenclature which has assigned this particular code to " Periodontal maintenance procedure following active therapy(periodontal prophylaxis)."[25] It was the conclusion of Dental Survey of America that periodontal services as listed below on page II-6 of the Ohio Medicaid Provider Manual were designed to not provide any periodontal services at all to anyone eligible.

E. PERIODONTIC SERVICES

- **Gingivectomy or Gingivoplasty**

***D4210** Gingivectomy or Gingivoplasty - per quadrant.

Prior authorization is required. Complete radiographs of the mouth and diagnostic models must be submitted.

Gingivectomy or gingivoplasty surgery is not usually covered under the Medicaid program. One exception is to correct severe hyperplasia or hypertrophic gingivitis associated with drug therapy or hormonal disturbances.

OAC cite: Rule 5101:3-5-07

One can only assume that those official who were responsible in putting these manuals together deliberately and intentionally designed program P&P which failed the practice of Dentistry in the treatment of dental disease in its amount, scope and duration. Thus we can conclude that Ohio Medicaid P&P in the area of Periodontics were intentionally designed to defeat the intent of Congress which design EPSDT legislation so that: (42 CFR 442 .457, .460.)

> "Comprehensive treatment services for all clients , which include dental specialties of pedodontics, orthodontics, periodontics, prosthodontics, endodontics, oral surgery, and oral medicine as indicated as well as comprehensive preventive dentistry programs.[26]"

As with many State run Medicaid Dental Programs such as Wisconsin, Michigan, Florida, Arizona the Ohio Medicaid Dental Program(below) suggest that their periodontal treatment is apart of its Preventative Service under prophylaxis care.

> "that prophylaxis includes the necessary scaling of the teeth to remove calculus deposits and the polishing of the teeth."

D1110 Dental prophylaxis, recipients ages 21 and older.

D1120 Dental prophylaxis, recipients through age 20.

> "both procedures for dental prophylaxis for recipients age 20, and 21 will not be reimbursed more frequently than once every 180 days."

The American Dental Association Council of Dental Care Programs along with the American Academy of Periodontology clearly has stated in the associations reports JADA Vol. 102.(March 1981) that:

> "Oral prophylaxis applies only to preventive measures used to-prevent disease and is not used to treat periodontal disease. Theses scaling and polishing procedures **are not used** to treat the periodontal disease found in case type II, III, and IV."[27]

The American Dental Association Council on Dental Care Programs association report on Reporting periodontal treatment under dental prepayment plans of March 1981 defines Dental Prophylaxis(01110) Adults and Children(01120).

> "Oral prophylaxis is a scaling and polishing procedure performed on dental patients in normal or good periodontal health to remove coronal plaque, calculus, and stains to prevent caries and periodontal disease."[28]

ORAL SURGERY

The State of Ohio Dental Medicaid Program frustrates EPSDT and the will of the Congress to provide health care in the area of Extraction of Asymptomatic impacted Teeth. The statements below once again clearly demonstrates how Ohio, Florida, and Michigan, Medicaid policies represent a **clear and present danger** to the medicaid recipient. The P&P from these states listed below are technically incorrect and in violation of Federal EPSDT guidelines. Dental providers from these states are being required to provide substandard Dental Care in the area of Oral Surgery.[29]

State of Ohio:

> "The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not covered."[30]

State of Michigan: Rev. 5-20-82, Chapter III pg 32. Medicaid Dental Manual

> " The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt pathology is not covered."[31]

The State of Florida: HRSM 230-22 Dental Provider manual for Childrens Dental Services to provide health care than in the area of **Extraction of Asymptomatic impacted Teeth.**

> "(3) The surgical removal of asymptomatic third molars is not compensable. Surgical removal of third molars as a preventive or prophylactic measure is likewise not compensable. **Since full bony impaction are rarely symptomatic**, more attention is given to soft-tissue or partial bony impaction.[32]"

Raymond J. Fonseca DMD, Chairman of the Department of Oral and Maxillofacial Surgery University of Michigan states,"the contention that bony impaction are rarely symptomatic is **erroneous**."[33]

The Appeals Court Concluded in **Mitchell v Johnston** that:

8.Non symptomatic Extraction of impacted Teeth.

> The district court also concluded that nonsymptomatic extraction of impacted teeth was a necessary EPSDT service and **we agree**. The testimony at trial clearly indicated that dental conditions do not always manifest themselves in the form of overt symptoms. Thus the district court correctly held that the purposes of the program were frustrated since the treating dentist was required to wait until the condition culminated in overt, painful, costly symptoms before extraction was an allowable procedure. Record, vol 4 at 775. Quite clearly, several severe dental problems could develop without overt symptoms. Record, vol 10 at 199-200. Hence, the elimination of this medically necessary service was improper.[34]

The American Association of Oral and Maxillofacial Surgeons(AAOM) has stated in their Newsletter that, "timely removal of impacted and unerupted teeth(e.g., third molars), preferably between the ages of 15 to 25, is a valid and scientifically sound treatment rationale. The overwhelming body of clinical evidence shows that patients with impacted teeth who wait until symptoms appear before having them removed suffer risks of undue discomfort, prolong recovery periods, increase cost of treatment and danger to their general health. The popular concept that if impacted and unerupted teeth don't bother you, don't bother them. is not supported by the weight of clinical evidence compiled over many years. The AAOM recommends that the public should consult an oral and Maxillofacial surgeon or dentist before any problems develop. This is preventive dentistry. Waiting for impacted and unerupted teeth to cause pain or more serious problems will only result in unnecessary complications and additional cost for treatment."

Any one who was in prosession of a pencil and a piece of paper could have written the **American Association of Oral and Maxillofacial**

Surgeons at 211 E. Chicago Ave, Chicago IL 60611 or call at 312-642-6446 and gotten the newsletter on Impacted and Unerupted Teeth for **free.**[35]

CONCLUSION

Ohio Medicaid Provider Handbook Dental Services Chapter3335 is an insult to modern Dentistry. The policies and procedures in the Ohio Medicaid Dental Manual are contrary to the practice of modern Dentistry and is a **imminent danger** to humans residing in an around the State of Ohio. Dental Survey of America feels that Governor Richard Celeste would be better off to close the Chapter on the Ohio Medicaid Dental Program and start all over again. The Governor can start by hiring a staff headed Dr. Don Bower Director of Admission at Ohio State University College of Dentistry along with Dr. Portia Bell both of whom are thoroughly capable in rewriting the New Ohio Dental Medicaid Program.

1. A GUIDE TO DENTAL CARE **EPSDT-MEDICAID**, BY Roy L. Lindahl DDS, MS., Wesley O. Young, DMD, MPH., prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics under Contract SRS- 73-49, Social Rehabilitation Service, U.S. Department of Health, Education, and Welfare, page 5-6.

2. IBID.

3. The original provision withheld one percent of federal AFDC payments otherwise due from any state that failed to inform screen and treat eligible children. See **42 USC Section 602(g) (l972)**. In l981 the so-called penalty provision was removed and the Medicaid statute was amended to incorporate these affirmative action provisions as a state plan requirement. **Section 2181 of Pub.L. 97-35, 95 Stat. 357(l981), codified at 42 USC Section l396a(a)(44) (l982)**.

4. Early Periodic Screening Diagnosis and Treatment(EPSDT)

Regulations. Transmittal Notice To: All State Medicaid Directors and EPSDT Coordinators. (May 9, 1985.)
The EPSDT regulation **(effective January 29, 1985) at 42 CFR 441.56(c)(2)** require, just as the previous regulations did **(42 CFR 441.56(b)(2))**, that States provide for "Dental Care ...needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," States will be cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT) **by July 1, 1985.**

5. 42 CFR Section 440.230 (b) 1985)

6. Maximizing The Use of the EPDST Program in the Delivery of Dental Care to Low-Income Children by Kay A. Johnson, M.P.H., M.Ed. of the Children's Defense Fund, 122 C Street N. W., 4th Floor, Washington D. C. , 20001. A paper prepared for the American Public Health Association Annual Meeting in Las Vegas, 1986.

7. IBID.

8. Mitchell v Johnston cite as 701 F.2d 337 (1983)

9. Maximizing The Use of the EPDST Program in the Delivery of Dental Care to Low-Income Children by Kay A. Johnson, M.P.H., M.Ed. of the Children's Defense Fund, 122 C Street N. W., 4th Floor, Washington D. C. , 20001. A paper prepared for the American Public Health Association Annual Meeting in Las Vegas, 1986.

10. Why Poor Johnny Doesn't Smile. by Norman J. Clement DDS., copyrighted fall 1988, Journal of Pedodontics.

11. Ohio Medicaid Provider Handbook Chapter 3335 ,Dental Services II. Covered Services and Associated Limitations Issued 1-4-88 Page II-6.

12. Florida in HRSM 230-22, October 15, 1981, 4-5. Endodontic, pg 4-3.

13. HOW THE MEDICAID DENTAL PROGRAM IN AMERICA IS A NATIONAL DISGRACE, BY NORMAN J. CLEMENT DDS DARYL E. WILLIAMS DDS. MS. DALTON SANDERS DDS, copyrighted Journal of Pedodontic, Sept. 1988.

14. Pulp Therapy for Children and Adolescents, Chapt. 5., page 138, by Ronald J. Pruhs, DDS., M.S., from TECHNIQUE IN CLINICAL ENDODONTICS , Gerstein, Harold 1983.

15. THE AMERICAN ASSOCIATION OF ENDODONTIST, manual of Procedure definitions 1985.

16. Pulp Therapy for Children and Adolescents, Chapt. 5., page 139, by Ronald J. Pruhs, DDS., M.S., from TECHNIQUE IN CLINICAL ENDODONTICS , Gerstein, Harold 1983.

17. Ibid, pq. 138.

18. IBID, pg. 136.

19. Maximizing The Use of the EPDST Program in the Delivery of Dental Care to Low-Income Children by Kay A. Johnson, M.P.H., M.Ed. of the Children's Defense Fund, 122 C Street N. W., 4th Floor, Washington D. C. , 20001. A paper prepared for the American Public Health Association Annual Meeting in Las Vegas, l986.

20. IBID.

21. 42 CFR Section 440.230 (b) 1985)

22. A GUIDE TO DENTAL CARE **EPSDT-MEDICAID**, BY Roy L. Lindahl DDS, MS., Wesley O. Young, DMD, MPH., prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics under Contract SRS- 73-49, Social Rehabilitation Service, U.S. Department of Health, Education, and Welfare, page 44 .

23. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) COMPARATIVE REVIEW OF THE STATE OF ARIZONA(AHCCCS) MEDICAID

DENTAL PROGRAM,**BY DENTAL SURVEY OF AMERICA** NORMAN J. CLEMENT DDS. ,DARYL E. WILLIAMS DDS. MS.,DALTON SANDERS DDS.,BRANDON BARTON DDS.

24.Arizona Health Care Cost Containment Systems (AHCCCS) Dental Codes Attachment 1 to Dental Policies 2.8.1 and 2.8.2 effective 10/1/85, Page 2.

25. American Dental Association CODE ON DENTAL PROCEDURES AND NOMENCLATURE section VI pg. 21.

26. Dental Services. 42 CFR 442 .457, .460.

27. The American Dental Association Council on Dental Care Programs association report on Reporting periodontal treatment under dental prepayment plans of March 1981, JADA VOL. 102.

28. IBID.

29. HOW THE MEDICAID DENTAL PROGRAM IN AMERICA IS A NATIONAL DISGRACE, BY NORMAN J. CLEMENT DDS DARYL E. WILLIAMS DDS. MS. DALTON SANDERS DDS, copyrighted Journal of Pedodontic, Sept. 1988.

30. Ohio Medicaid Provider Handbook Dental Services, issued 1-4-88, page II-8.

31. **State of Michigan**: Rev. 5-20-82, Chapter III pg 32. Medicaid Dental Manual.

32. From HRSM 230-22(Florida) October 15, 1981 Page 4-7, 4-12 Oral Surgery.

33.Letter from Raymond J. Fonseca DMD, Chairman Department of Oral and Maxillofacial Surgery University of Michigan, to Norman J. Clement DDS , March 3, 1987.

34.Mitchell v Johnston cite as 701 F. 2d 337 (1983) p.p. 350

35. American Association of Oral and Maxillofacial Surgeons at 211 E. Chicago Ave, Chicago IL 60611 or call at 312-642-6446; Newsletter on Impacted and Unerupted Teeth for.

THE TOOTHGATE SCANDAL

HOW THE STATE OF FLORIDA'S DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES HAVE OPERATED THE MEDICAID DENTAL PROGRAM(EPSDT) ILLEGALLY

SECOND IN COMPARATIVE REPORT FROM
DENTAL SURVEY OF AMERICA
by Norman J. Clement DDS

DRAFT

INTRODUCTION

In March of 1989 Dental Survey of America, published the first of its comparative reviews of State-run Federally Funded Medicaid Dental Programs Manuals. We reported that Florida's Children's Medicaid program manual HRSM 230-22 was in **non compliance** with its own state regulations governing the practice of modern dentistry. We also reported that the Florida Children's dental program was in clear **violation** of federal guidelines as set forth by Congress and the Health Care Financing Administration (HCFA) for the Administering of Medicaid Dental Programs.

Effective January 1, 1989, Consultec Inc. replaced Electronic Data Systems **(EDS)** as the fiscal agent for Florida Medicaid Program an a updated new manual went into service effective the same date. This handbook was prepared through a combined effort of Florida's Department of Health and Rehabilitative Services (FHRS) and Consultec using regulations and guidelines established by FHRS and the federal government. Dental Survey of America has done a comparative review of the Florida Consultec Dental Program manual and is publishing this report which gives more cause for alarm and is more disturbing than any of our five previously published studies.

METHOD

For the purposes of this study Dental Survey of America has done a side by side comparison on policy and procedure definitions of Florida's Children Dental Service manual HRSM 230-22 with those of the new Florida Consultec manual. Each comparison is followed up by a brief legal explaination.

To obtain background information on manual developement, we sought a series of corespondences from the American Dental Association to the Florida Dental Association and Dental Survey of America's Norman J. Clement. Also we sought corresondence between offices of Florida State Represenatives Alfred Lawson of Tallahassee and Jack Tobin of Ft. Lauderdale directed to Florida Department of Health and Rehabilitative Service the Administrative arm of the Florida medicaid program.

DRAFT

DISCUSSION

The Florida Consultec Medicaid Manual is an imoral outrage to the practice of modern dentistry. Dental Survey of America found what appears to be the delibrately and willful intent on apart of officials managing the Florida medicaid dental program to maintain policy and procedures that are substandard with Children's Dental Health Care. There is no doubt that other state run medicaid dental programs are in the same category as seen in Florida but Dental Survey of America clearly found that the State of Florida was truly the worst offender of our national dental public health policy as set forth under EPSDT regulations.

As with Florida's HRSM 230-22 Dental Survey of America found dental policies and procedures in the Florida Consultec manuals that were outdated, outmoded, or otherwise incorrect with the practice of modern dentistry. We also continued to find dental policy and procedures that are nonexistent in the practice of dentistry. One clear example was the identification for extractions of supernumerary teeth by tooth numbers 61,62,63. This identification system is found nowhere in modern dentistry. Still other examples include the accelerated removal of healthy teeth in order to qualify some children for removable partial dentures. The adult dental services program still maintains a policy that requires the total removal of teeth even though the medicaid recipient may have pain of a single tooth or wanting a single dental X-ray. One seemingly begins to wonder what feendish madness was present in the develpement and the final approval of the Consultec manual.

In fact this new updated Children's Dental Service Manual is just that, and updated manual; Florida officials have just merely looked up the date and changed it from October 15, 1981 to January 1, 1989. Moreover, any previous report Dental Survey of America has done on HRSM 230-22 is the same for the Consultec manual; these two manuals are one in the same. Incredibily, this simple change of date cost the state of Florida and Federal Government 9 million dollars. Florida is not alone, the State of Massachusetts which has over the years been given high marks for its medicaid program did exactly the samething as Florida has done with its new dental medicaid manual.

Both the Florida and Massachusetts manuals are in there content one in the same. We found these manuals were written by lay people who knew nothing about the practice of dentistry. What was most incredible is that these lay people from state to state just copied each others manuals until many of them had the same grammatical, technical, and spelling errors. In fact it became evident that any dentist who treats and accepts assignment on medicaid recipients could very easily find himself/herself on the **RIGHT SIDE OF DENTISTRY BUT ON THE WRONG SIDE OF THE LAW**. What most citizen in our country are not aware of is that throughout America the Medicaid Dental Program are being illegally operated outside the practice of dentistry and most states run medicaid programs are in violation of federal Mandates, federal laws and federal court orders. We explore the developments of the Consultec Manual.

THE MAJOR DECEPTION

In Florida, the office of The Deputy Assistant Secretary for medicaid is responsible for developing the statewide policies and procedures for the Children's Dental Service Program and for all other services offered under the Medicaid Program.[1] On December 8, 1986 Florida, State Represenative Jack N. Tobin of Ft. Lauderdale, then Chairman of the Florida's, Committee on Health & Rehabiliatative Service at the request of State Represenative Alfred Lawson of Tallahassee wrote then Deputy Assitant Secretary of Florida Medicaid Program Judy E. Mitchell. Mr. Tobin specifically asked:

> "It has come to my attention that some of the procedures contained in the Medicaid Children's Dental Services Manual (HRSM 230-22) may be outdated...I would very much appreciate your providing me with a description of the process used to develop and adopt the policies and procedures contained in the manuals. I am also interested in determining who has responsibility for establishing and altering the policies and procedures in the manuals and how often the manual is reviewed to consider revisions."

Fig 1.

Dear Ms. Mitchell

According to section 409.266(10), Florida Stautes, the Department of Health and Rehabilitative Services may impose administrative sanctions for cause on a provider participating in the Medicaid program. This includes a situation in which a providers is in noncompliance with officially adopted Medicaid policy manuals, the Florida Administrative Code, the Florida Statutes, or fedral Medicaid rules or regulations. It has come to my attention that some of the procedures contained in the Medicaid Children's Dental Services Manual (HRSM 230-22) may be outdated.

I would very much appreciate your providing me with a description of the process used to develop and adopt the policies and procedures contained in the manuals. I am also interested in determining who has responsibility for establishing and altering the policies and procedures in the manuals and how often the manual is reviewed to consider revisions.

Your comments on these issues will help me to better understand the Florida medicaid Program. Thank you in advance for you assistance.

Sincerly

Jack N. Tobin

Chairman

10 days latter on December 18th Ms. Mitchell's office responded to the request of Mr. Tobin. The response letter, written on behalf of Ms. Judy N. Mitchell by Medicaid Program Director Morine Funderburk (MF) was received in his office on December 29 1986. She stated that:

> "...The policy manuals for Medicaid are the responsibility of the Office of Program Development within my office of the Deputy Assistant Secretary for Medicaid. These manuals are reviewed annually for updates, but may be revised more or less frequently depending upon program changes. The Children's Dental Services Manual, for instance, was revised in November 1982, July 1983, January 1985, and July 1986. These revisions included informational and procedural changes as well as service expansion.
>
> The manual was originally developed in 1981 by a team of dentists and staff. Prior to publishing our manuals, an extensive departmental review is required to assure consistency with other programs and the avoidance of duplication. As recently as October 1986, this manual was distributed to the Florida Dental Association, the Florida Medical, Dental and Pharmacy Association, the University of Florida Pediatric Dentistry Department, and private dentists who act as consultants to the Medicaid program. Respondents' comments were limited to our low fee schedule, not policy changes or clarifications."

Fig. 2

DRAFT

Dear Represenative Tobin:

You requested information relative to the development of policies and procedure governing Florida's Medicaid program. In particular, you were interested in the Children's Dental Services Manual (HRSM 230-22).

The policy manuals for Medicaid are the responsibility of the Office of Program Development within my office of the Deputy Assistant Secretary for Medicaid. These manuals are reviewed annually for updates, but may be revised more or less frequently depending upon program changes. The Children's Dental Services Manual, for instance, was revised in November 1982, July 1983, January 1985, and July 1986. These revisions included informational and procedural changes as well as service expansion.

The manual was originally developed in 1981 by a team of dentists and staff. Prior to publishing our manuals, an extensive departmental review is required to assure consistency with other programs and the avoidance of duplication. As recently as October 1986, this manual was distributed to the Florida Dental Association, the Florida Medical, Dental and Pharmacy Association, the University of Florida Pediatric Dentistry Department, and private dentists who act as consultants to the Medicaid program. Respondents' comments were limited to our low fee schedule, not policy changes or clarifications.

As you can see, we have involved participants from the dental profession in the development of our policies and procedures. We feel that this is especailly critical in a service such as dental where we try to provide as comprehensive a service array as possible with our limited funding.

I hope this clarifies our manual development process for you. If you have any further questions, please call me at (904) 488-3560.

Sincerely,

Judy E. Mitchell
Deputy Assistant Secretary
for Medicaid

JEM: MF: djw

cc: Office of Legislative Planning
and Analysis (HRS)

Mr. Tobin's office on January 15th 1987 forwarded Ms. Mitchell's letter to Florida State Represenative Alfred Lawson Jr. of Tallahassse which was received by his office on . Mr. Lawson's office then forwarded all correspondent transaction to Norman J. Clement of Dental Survey of America which were received in his office a few days later.

January 15, 1987

Honarable Alfred Lawson , Jr.
Stae Representative, District #9
311 House Office Building
Tallahassee, Florida 32301

Dear Represenative Lawson:

On December 8, 1986, I request information from Ms. Judy Mitchell, Deputy Assitant Secretary for Medicaid at the Department of health and Rehabilitative Services regarding thew Chjildren's Dental Service Manual. Please find enclosed a copy of her response to my inquiry.

I hope this information is useful to you. Please let me know if I can be of further assistance.

Sincerely,

Jack N. Tobin
Chairman

JT:mdv

Enclosure

On January 13th and 14th the **American Dental Association's** Assistant Secretary, Council of Dental Care Programs, Ms. Jasna Stocic came back with their review of the both Florida Medicaid maunals (Children's Dental Service Manual (HRSM 230-22), HRSM 230-21, Adult Dental Service Manual) in which Ms. Mitchell specifically stated to Florida State Represenative Jack Tobin that:

> "manuals are reviewed annually for updates, but may be revised more or less frequently depending upon program

changes. The Children's Dental Services Manual, for instance, was revised in November 1982, July 1983, January 1985, and July 1986. These revisions included informational and procedural changes as well as service expansion."

In her first letter dated January 13th which was address to Mr. Bob MacDonald Assistant Executive Director of the Florida Dental Association she specifically stated:

> ... many of the definitions or restrictions on procedures are inconsistent with the Association's recommendations. I think Dr. Clement's point is valid- **these manuls do appear to be outdated**."

Fig. 3

In her second letter dated January 14, 1987 address to Norman J Clement DDS, she reiterating ADA's findings on policies and procedure found in both Children and Adult Services medicaid manuals and specifically states.

> ***"I have asked another Council staff member to review the manuals, in particular the areas that you had identified. She found some procedure definitions to be inconsistent with the nomenclature in the Association's Code on Dental Procedures...and other procedure definitions to be incomplete or otherwise incorrect, based on current accepted dental practice. The comments I heard during the videotaped meeting- that the manuals lack clear, concise definitions-are accurate. I think both manuals need to be revised and updated."***

Fig. 4

January 13, 1987
Mr. Robert MacDonald
Assistant Executive Director

Florda Dental Association
3021 Swann Avenue
Tampa, Florida 33609
Dear Bob:

As you and I discussed this morning, enclosed is the material I received from Dr. Norman J. Clement, Tallhassee.

Dr. Clement has had a problem with Medicaid- suspension (and subsequent reinstatment) from poarticipation in Medicaid because of alleged fraud. If you will read his letter to CBS you will note that he identifies other practioners who have been charged with Medicaid fraud and he also identifies the reasons for these problems on the last page of his letter.

When I spoke with Dr. Clement, I explained that specific problems with a state Medicaid program are the responsibility of the constituent society, and that the Association provides assistances as requested and appropriate. I also indicated that I would review the material and share the material and my comments with the Florida Dental Association.

I am in no position to comment on the validity of Dr. Clement's assertions about Medicaid or Medicaid's actions against Dr. Clement. I have reviewed the enclosing material and am providing it to you with the following observations.

I have seen the videotape of the meeting with the FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICE (DHRS). Many of the issues that were identifies by Dr. Clement were brought up at that meeting- prior authorizations, recipient eligibility, payment dates for prothodontic treatment, payment for emergency treatment, and definitions in the HRS manuals for dental services. DHRS staff was competent in clearly explaining the requirements and provisions of the program, and acknowledgedf that the dental services manuals need to be revised They appeared very willing to work with dental organizations in updating the manuals, as well as to address other problems with the dental component, of Medicaid. I believe you when you say FDA has a good working relationship with the Medicaid program.

I have asked another member of the Council staff, one who is much more knowlewdgeable than I am about dental proceduires and clinical definitions, to review the two manuals, most specifically those areas indentified by Dr. Clement. Her comments are noted in red. While her review was not exhaustive, you will see from her notes that may of the definitions or restrictions on procedures are inconsistent with the Association's recommendations. I think Dr. Clement's point is valid- **these manuls do appear to be outdated**.

Bob, I would appreciate you handing of this matter as you suggested this morning. Please keep me informed. If I can be of any assistance to you, just let me know.

Sincerely

Jasna Stocic
Assistant Secreatary
Council on Dental Care Programs

JS:cm
Enclosure

cc: Dr. James L. Cassidy, Council memeber, ADA
American Dental Association

January 14, 1987

Dr. Norman J. Clement
Leon Medical Building
1617 Physicians' Drive
Tallahassee, Florida 32308

DRAFT

Dear Doctor Clement:

As I indicated to you during our recent telephone conversation, I had received the material you sent but had not had the opportunity to review it.

I have reviewed the videotape and I noted that many problems with the dental component of Medicaid were discussed during the meeting with DHRS and EDS. The DHRS officials acknowledged that the manuals need revising and that some efforts have been made in this regard. I was encouraged by the apparent willingness of DHRS and EDS representatives to have dental organizations participate in the revision process.

I have asked another Council staff member to review the manuals, in particular the areas that you had identified. **She found some procedure definitions to be inconsistent with the nomenclature in the Association's Code on Dental Procedures and Nomenclature (attached), and other procedure definitions to be incomplete or otherwise incorrect, based on current accepted dental**

practice. The comments I heard during the videotaped meeting- that the manuals lack clear, concise definitions-are accurate. I think both manuals need to be revised and updated.

As I also explained to you during our telephone conversation, problems with state Medicaid programs are the responsibility of the constituent dental society, with the Association ready to assist as requested and appropriate. I have spoken with Mr. Bob MacDonald, assistant executive director, Florida Dental Association, about this issue. Bob indicated that a good working relationship has been established with DHRS, and that the dental society's input is facilitated through Dr. Chris Scures, a dentist who serves on the Medicaid Advisory Council. Bob also indicated that the dental component of Florida's Medicaid program is being reviewed and that problems with the program will be brought to the attention of the new Governor.

Bob asked that I forward the material you sent to me to his attetion, which I have done. The Florida Dental Association's Council on Dental Care will be meeting in the near future, at which time they will have the opportunity to review the manuals. I am confident that the need for updating and revision of these manuals will be appropriately communicated to DHRS.

I appreciate your bring this matter to the attention of the Council.
Sincerely,

Jansa Stosic
Assistant Secretary
Council on Dental Care Programs **DRAFT**

JS:cm

cc: Dr. James L. Cassidy, Council on Dental Care Programs
Mr. Robert MacDonald, assistant executive director Florida Dental Association

DSA has contacted the Florida Dental Association and the Florida Medical Dental and Pharmaceutical Association and each of the professional organization has stated in writing that they had neither seen nor were they ever consulted on changes in policy or procedure in HRSM 230-22 or 230-21 in October of 1986. In fact on February 2, 1987, Charles Hinton Assistant Executive Director For Govermental Affairs of the FDA Tallahasse office wrote:

> "The Association appreciates your concern regarding the medicaid manuals and your suggestion that the manuals be reviewed. In fact, I have learned since talking with you that the Department of Health and Rehabilitative Service has requested that the Association review the manuals."

February 2, 1987

Dr. Norman J. Clement
P.O. Box 13326
Tallahassee, Florida 32317

Dear. Dr. Clement:

Enclosed are the materials you sent to the Florida Dental Association pertaining your problem with the Medicaid program. The Association appreciates your concern regarding the medicaid manuals and your suggestion that the manuals be reviewed. In fact, I have learned since talking with you that the Department of Health and Rehabilitative Service has requested that the Association review the manuals. Both your suggestion and the Departments request are being considered.

Thank you for brining this matter to my attention

Charles O. Hinson, III
Assistant Executive Director
For Govermental Affairs

CH:ay
Enclosure

Fig. 5

From this letter it becomes clear that the Florida Dental Association was never consulted in October of 1986 to review the Childrens and Adults Medicaid dental program manuals as indicated by then FHRS Deputy Director of Medicaid Judy N. Mitchell. Mr. Hinson has gone on further, and stated to Mike Kevich of Florida Tax Watch, and James Brown Phd, vice president of the Tallahasse Chapter of the NAACP that the Florida Dental Association has acted as consultants but has never signed off or approved any of the Florida Medicaid Manuals. This Co-author Norman J. Clement as an active member of the Florida Medical, Dental and Pharmaceutical Association along with all the member of our Association have categorically gone on record in denying that we have ever acted as consultants nor have we ever sign off or approved any of the Florida Medicaid Manuals.

In March of 1989, Norman J. Clement of Dental Survey of America contacted Dr. Carol White Professor of Pediatric Dentistry at the University of Florida and a member of the Editorial Board of the Journal of Pedodontics. He repeated to Dr. Clement that the University of Florida College of Dentistry has never acted as a consulted nor did their department ever approve the dental manuals for children or adults. In fact Dr. White went further to say that their has been great disatisfaction amongst Pediatric Dentist in Florida with the medicaid dental program.

During the summer of 1985 the Children's Defense fund conducted a 50 state survey of EPSDT Programs on a wide range of issues. These included the role of the Dental Proffessional in the developement of standards for the content and timing of care. Other issue included whether the state reimburses providers other than dentist for screening or any other procdeures; and basis on which the state provides reimbursements. With regrads to the consultation of dental professional organizations in structuring the programs, CDF found 3 states reported having no such involvement. Further more of the 44 states reporting professional consultation six admitted to having only involved dental health professionals in the intial structing of the program sometimes as long as 10 years ago.

SIDE BY SIDE COMPARISON OF DRAFT FLORIDA'S HRSM 230-22 11/81, WITH CONSULTEC 1/89

Florida Medicaid Dental Handbook HRSM 230-22 October 15, 1981 section 4-12 Oral Surgery page 4-7.	Consultec Medicaid Dental Provider Handbook Children's Dental Service Effective Date 1-89, Oral Surgery page 11-15.
Simple extraction is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extractions can be performed as necessary. HRS will investigate an unusual number of simple extractions in the **primary dentition** to ensure that a significant health service has been performed.	**Simple extraction** is the removal of a permanent or deciduous tooth by the closed method or "forceps only" technique in which a flap is not retracted. All simple extractions can be performed as necessary.
Florida HRSM 230-22, Page 4-7, October 15, 1981	Consultec Medicaid Children's Dental Service Date 1-89, Oral Surgery page 11-15.
Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to **extract or section of a tooth.**	Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to **extract or section of a tooth.**
Florida HRSM 230-22, pg. 1-8. October 1, 1981. The surgical removal of asymtomactic third molars is not compesensable. Surgical removal of third molars as a preventive or prophylactic measure is likewise not compensable. Since full bony impaction are rarely symtomatic, more attention is given to soft tissue or partial boney impaction. All prior authorization request for the surgical removal of third molars must include a written statement from the dentist stating that symptoms of swelling, prevalent infection, or consistent pain is present.	**Consultec: Oral Surgery, pg. 11-16. January 1, 1989.** The surgical removal of asymtomatic third molars is not compesensable. Surgical removal of third molars as a preventive or prophylactic measure is likewise not compensable. Since full bony impaction are rarely symtomatic, more attention is given to soft tissue or partial boney impaction. All prior authorization request for the surgical removal of third molars must include a written statement from the dentist stating that symptoms of swelling, prevalent infection, or consistent pain is present.

Endodontics: Pulp capping HRSM-230-22, October 1, 1981.

"Pulp Cap. Pulp capping is differentiated from routine placement of a medication base or lining under a filling. The latter is included in the reimbursement for the restoration. Pulp capping may be separately reimbursed and is regenerative dressing over the exposed vital pulp. Both direct and indirect pulp cap is reimbursable."

Endodontics: Pulp Cap, pg. 11-10. (Consultec)

"Pulp Cap. Pulp capping is differentiated from routine placement of a medication base or lining under a filling. The latter is included in the reimbursement for the restoration. Pulp capping may be separately reimbursed and is regenerative dressing over the exposed vital pulp. Both direct and indirect pulp cap is reimbursable."

Partial Denture: HRSM- 230-22, October 1, 1981.

removable partial are only done where there are less than eight posterior teeth in occlusion

Partial Dentures: Consultec, pg. 11-11, January 1, 1989.

Partial Dentures are allowable where there are at least eight posterior teeth in occlusion.

As what become clearly evident there is not much that is chaange between the Florida HRSM 230-22 Children's Dental Service Manuals and the Consultec Manual of January 1, 89. Moreover these manuals are one in the same.

IN THE BEGINING THERE WAS MANUAL ERECTUS

"WHO WROTE THESE MANUALS AND WHEN WERE THEY WRITTEN?"

Who wrote the Medicaid Dental Provider Manuals and when did they write them? This is probably one of the biggest mysteries in the entire Toothgate episode and perhaps the answers is that the manuals were not created but they evolved. Just as Anthropologist suggest that the origins of Modern Man (homo sapien) evolved from a vertebrate spiece known as homo erectus, Dental Survey of America has found evidence which suggest that the origins of the dental provider manuals was likely from one source manual which we call Manual Erectus(M.E. theory). The Manual Erectus or ME Theory was advanced when DSA began noticing similarity in 3 of the state medicaid dental provider handbooks the Florida, Massachusetts, and Maine. These similarities were identical to even including the same spelling and grammatical errors. Tallahassee Orthodontist Irving Fleet against one Tallahasseo Dentist, Fleet stated that in 1981 he participated in the writing of the Florida Childrens Dental Program Manuals HRSM 230-22. Yet, when DSA spoke with Ms. Victoria Burwell who was the acting Medicaid Dental Director for the State of Maine she stated that their dental provider manuals was written by Dental Consultants in Maine and gave us the name of one of the dental consultants. The dental consultant for the State of Maine returned our phone and promptly congratulated DSA on its work of addressing the problems of Medicaid program manuals. He felt our research was long over due. While in Massachusetts Medicaid Program Director Linda Rand on June 12 1989 when interviewed by Dr. Norman J. Clement over the phone stated that 8 dental consultants assigned with the provider relations office reviewed and design the new Massachusetts Children's and Adult medicaid dental program manuals. The extent of the review nor the type of reviewing that was done to update these manuals were unavailiable to DSA, but it appears from the content of the new manuals released on March 17, 1989 that nearly all of the content of the old manual and the new manuals were identical an only the dates of the manuals had been changed to reflect any updating that had taken place. Incredible as this may seem the new updated Massachusetts and Florida are nearly identical word for word. When taken into consideration that the Michigan and Maine program manuals are too nearly indentical to Massachusetts and Florida, the probablity of these four states independently designing the same incorrect dental policy and procedures even right down to the same identical spelling, gramatical and technical errors 1 in 4 zillion. Clearly that probability suports the one source manual or the Manual Erectus theory.

WHOSE AT FAULT AND WHAT SHOULD BE DONE?

It is hard to imagine, that until Norman J. Clement, Dary E. Williams, Dalton P. Sanders, formed Dental Survey of America there had not been much bothered by anyone to check the validity of the dental policies and procedures found in medicaid Dental Provider Manuals which were being utilized by States. There had been very little, if any questions raised to whether policies and procedures conformed to Standard Dental care or even if such policies or procedures existed in the practice of dentistry. One would have thought that with the thousand of medicaid Dental providers in this country, Public Health Dental Consultants, Private Insurance Dental Consultants that someone would have questioned the integrity of this program but no one did. Most of the public, including, defense attorneys, prosecutors, congressman, reporters, even some States' Medicaid Directors had all assumed that medicaid dental program manuals were written and approved by dentist; Dental Survey of America has found otherwise. The fault lies in three areas, The Federal Government specifically the Department of Health and Human Services, all sectors of oraganize dentistry, State Boards of Dentistry and even including members of Dental survey of America who have only responded after medicaid had taken action against them. And, most importantly local state medicaid officials who have taken an indifferent attitude toward the standards of care in the dental health profession seeking only to provide quantitative service for the most patients for the least money, thus oral health care remains substandard.

The Department of Health and Human Service(DHHS) is the agency at the Federal level who mission is to promote and assure the highest level of health attainable for every individual in America. In response to directives from the Committees on Appropriations of the House of Representatives and the Senate to address the indentification of appropriate goals and priorities in oral health," and to consider appropriate organizational and administrative arrangements for achieving maximum coordination and effectiveness of dental health activities" within the Department of Health and Human Services(DHHS, an Interim Study Group on Dental Activities was formed. The Interim study group on Dental Activities was charged by the House and Senate Appropiations Committee with identifying goals and prioritites for oral health and sugessting ways of achieving maximum coordination and effectiveness in pursuit of these goals with in the Department of Health and Human Services (DHHS). The Study Group was composed of individuals from the public and private sector with broad backgrounds in oral health representing academia, research, manament, and the delivery of sewrvices. The Study group received oral and written testimony from individuals and major national health organizations. On May 16th, 1989 the Chief Dental Officer of the United States, Assistant Surgeon General Dr. Daniel F. Whiteside released to the public this study called Improving the Oral Health of the American People Opportunity for Action, which was highly critical of Dental health policies in America. This study in which Dental Survey of America submitted written testimony, concluded that, "Department of Health and Human Services dental activities were fragmented, lacking and uncoordinated, preventing DHHS from effectively carrying out its responsibilities. Most importantly the study was unable to identify within the Department either a discernable oral health policy, or a mechanism whereby oral health perspectives are assured of receiving appropriate consideration."

This study further pointed out that, " many state and local programs and other health organizations submitted testimony to the study group decrying the lack of a visible contact point for obtaining consultation or technical assistance from the Department in matters related to dentistry. Futhermore the study revealed that some agencies which reported oral health activities have **little or no oral health expertise within the agency**. Other information presented indicates that the communication lines essential to a constructive atmosphere and the effective coordination of national initiatives **are not** apparent. In the present environment," the study goes on to say, " the Public Health Service has little hope of fulfilling its leadership role in the development and maintenance of timely national oral health policies, goals, and implementation strategies."

Board of Dentistry and national dental Organizations are equally at fault for the dismay found federal funded state run programs. National Organization have become too pre-occupied with preventing national health insurance and Boards of dentistry lack leadership and have failed in their responsibility in protecting the public against unscrupolus dental programs. Memebership to the board of dentistry is more of a social club appointment handed out by the State governors. We found that in a number of states anyone having the money could write a dental program as terrible as the worst medicaid program in the country and as long as the program fulfill the requirements of the Department of Insurance that program would be license by the state and the Board of Dentistry would have nothing to say about it. During their 1985 Kay Johnson of the Children's Defense Fund in a paper prepared for the American Public Health Association Annual meeting in Las Vegas 1986 called Maximizing the use of the EPSDT program in the Delivery of Dental care to Low -Income Children stated, "The dental health component of EPSDT has become unnecessarily isolated from the overall program, despite the fact that the full spectrum of necessary dental service are required. Lack of data on program participation and service utilization contributes to this estrangement. Since Medicaid is the major source of payment for dental service provided to low-income childrewn (including many disabled children with special dental health needs) and EPSDT is the main structure through which services are provided, a well functioning program is essential to ensure chiuldren's receipt of dental care and dentist' willingness to participate. dental health providers should become more involved with the program and take a more active role in shaping it structure and content in order to allow it to better serve the child population and providers. Specifically, dental health porfessionals should become involved in advocating for improvements in program managwement data to better reflect dental service utilization; adjustments to state periodicity schedules and service packages to ensure that they are consisteny with dental professional standars; increases in use of dental healthg professionals organizations for consultation on program structure and content; enhancement in provider reimbursement levels as necessary to ensure that they do not deter dental health professional involvement in the program and expansion in eligibility to ensure that high risk low income children ages 5-18 are covered. Only a fractrion of the medicaid-eligible individuals receive oral health carte. These individuals not only have the least opportunity for access to oral health services, but it can be presumed that they also have the greatest need.

Oral health care providers in every state have complained that Local medicaid agencies frequently change rules making some procedure guidelines impractical to treat a child on medicaid. In some programs Medicaid officials had uniquely designed policy and procedure manuals which made no sense and made it nearly impossible for any dental providers to be reimbursed for their services. Medicaid Policy Review Boards and Committees required by Early Periodic Screening Diagnosis Treatment (EPSDT) legislation to review Dental Policies as set forth in program manuals were found in several states to be ineffective or non-existent.

Providers have increasingly been frustrated with medicaids' multitude of problems especially archiac reimbursement patterns, electing to instead terminate their status as medicaid providers. There is overwheliming evidence that many of these States have deliberately changed these rules to save money at the expense of the patients' care and the providers of that care. The hopes that local dental organizations and boards of dentistry can provide input into these programs to the standard care of dentistry has long past. Some state programs have become so indiferrent to the practice of dentistry, Federal guidelines as set forth by Congress for the Administering of Medicaid

Dental Programs and latent with corruption that the only way to effectively resolve this crisis is through Congressional Oversight and Investigation. This must then be followed by indictments and vigorous criminal prosecution of these local state medicaid officials by the U.S Justice Department.

This tragic set of bureaucratic bugling on the federal level explains why Dental Survey of America found in its review of State medicaid program manuals dental, policies and procedure varying so widely that what may be standard practice of dentistry in one state could be felony fraud in another. Hapless, mismanagement by state officials in zeal to prosecute oral health care providers even on the most miniscule of error including errors admitted caused by the local state run medicaid agency has resulted in a significant number of dentists finding themselves on the **right side of dentistry but on the wrong side of the law**.

CONCLUSION

Based on the research previously done by Dental Survey of America, which has clearly established that many States had undermined the integrity and intent of Congress under EPSDT(Early Periodic Screening, Diagnosis and Treatment) Legislation to provide all Comprehensive Dental Care and medically necessary orthodontics by hindering health care providers through harassments, indictments, and prosecutions. On February 17, 1989 Congressman Lewis Stoke requested the Chairman of the U.S. House, Subcommitee on Health and Environment to conduct a full review of medicaid dental programs.

On April 17, 1989, Dental Survey of America received a letter from the offices of Congressman John Dingell, Chairman, Committe on Energy and Commerce adjoined with Congressman Henry A. Waxman Chairman, Subcommittee on Health and Environment requesting Dr. John H. Gibbons, Director, Office of Technology Assessment to conduct a study on dental care provided under Medicaid.

The study will ascertain whether the dental care provided to Medicaid beneficiaries, particularly to children eligible for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. conforms to the standards norms of dental practice. For the puirpose of this study, dental care gudelines issued by federal agencies (e.g., the Health Care Financing Administration dental guidelinea for the EPSDT program) and dental professional groups (such as the America Dental Association, and the American Academy of Pediatric Dentists) suggest a minimum standard of dental care.

The study should evaluate a represenative sample of five or six State Medicaid programs, chosen by OTA, for their conformance with a minimum standard of dental care, as defined in Fedral and professional gudelines. The Study should also include, if possible, some measure of the actual dental care received under the State programs.

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1. Children's Dental Service, HRSM 230-22,pg. 2-1, October 15, 1981.

23302 Hollander
Dearborn, Mi 48128
6/28/89

Senator Donald Riegle, Jr.
Chairman of the Senate Finance Subcommittee
on Health for Families and the Uninsured
United States Senate
Washington DC 20510

Dear Senator Riegle,

I am grateful that the problems confronting individuals who are uninsured are being addressed by you and your committee. I look foreward to a solution that will give everyone proper health care in the *near* future with prevention being a high priority thrust.

Access to medical care should be a right and available to everyone. The dilemma many of our youth face today in trying to survive is overwhelming. Basic health care along with affordable housing and even food must vie with each other as a priority forcing choices of which essential bill to pay of rent, clothing, food or medicine. It is virtuously impossible to follow a plan of saving for the future.

It is a disgrace that those who are trying to be self sufficient and make a go of it are forced to subsist below poverty level without adequate medical care. The health care of those without employer paid insurance for medical care is jeopardized. The insurance for medical service & medicine and dental work is non affordable.

Many are working without the benefit of medical coverage making it virtually impossible for them to succeed. Our inadequate public transportation system adds to the dilemma. The costs and expenses of a car take from the food, shelter & clothing needs as well as medical and dental care.

The education of our population, including the medical profession, toward a holistic approach to health is vital. The prevention of disease with the emphasis of wellness of body, mind and spirit must be a part of this solution — not just the curing of disease. This prevention goal should be a right of all as well as health care.

It is unforgivable that all of us in this country take back seats to the huge military budget. The waste of resources in this way in lieu of great human need is deplorable.

Senator Riegle, I see my children struggling to make ends meet. One is in the Community Mental Health system and is also working in a job that has not provided medical coverage as yet. He has been uninsured for five years. His teeth have been neglected. It is the juggling of which first for his paycheck! He is not on SSI and struggles to remain independent. The odds for success are very much against him.

My husband is nearing retirement and I have already done so. We recognize that our children are in a precarious position and we are helpless to assist them in a significant monetary way. We do assist them to being self sufficient to the extent we are able. As we become a part of the elderly population we also are vulnerable... We look forward to a resolution to the adverse conditions present in this Country soon with great anticipation.

Sincerely,
[illegible] Zerger

Donald Riegle Jr.
Senate Building
Washington DC 20510

3377 Edgewood
Dearborn Mich. 48124
June 27, 1989

Dear Senator Riegle

Trying to afford health insurance can be impossible for people not covered by their employers. Many people go uninsured for the simple fact that it is too expensive. The job I am currently holding does not offer medical insurance. With a salary of about six hundred and fifty dollars a month, I barely get by each month. Rent in the area I live in starts anywhere from three hundred dollars and up for one month. Any young adult of my age trying to make it on their own find out it is very difficult. My living expenses include; car insurance, a bank loan, rent and health insurance. I live week by week, and the last expense on my list is food.

For three more months I will recieve the discount health insurance coverage from my father's employer. I have a hard time beliving that it is discounted. I pay one hundred and thirty dollars a month for my health insurance. This does not includ, dental work which I really need. I have now missed my six month check-up because of low cash funds.

Our society is in desperate need for sufficent medical care for everyone. Cheaper insurance would allow for many uninsured people to be able to afford health insurance. I would be so greatful for changes in the laws governing medical care and heath insurance in our society

Sincerely yours,

June 26, 1989

Senator Donald W. Riegle, Jr.
1850 McNamara Fed. Bldg.
477 Michigan Ava.
Detroit, MI. 48228

Dear Senator:

I was very pleased to receive your letter regarding your interest in access to health care. My daughter is divorced and trying to raise and provide for two children. Her ex-husband has been recently fired from his job, and the insurance, health and dental care was his responsibility. Consequently, the children now have no coverage. This really worries me.

My daughter works part time in order to pay the necessary bills and cannot afford health insurance. Detroit Edison has offered her "COBRA" coverage for $300/month, and her present employer has also offered her insurance at the same rate. This is out-of-reach on her present budget. She went to the Social Services Dept., but since her car is a 1986 model and she has a little savings account, she is not eligible for assistance.

Why can't the government help someone who is trying to help herself? It would be easier for her to go on ADC and get a full "free ride", and be able to spend all her time raising her children, than to work and struggle. It is more beneficial for the government to give a person a little help than fully provide for them. It would be more economical and also provide an atmosphere for pride and self-worth and independence to the people involved, rather than be a victim of the system.

Keep up the good work.

Sincerely,

Jackie Zyjewski

Mrs. David Zyjewski
17615 Smith
Riverview, MI. 48192

jz